Sarah Bush Lincoln

NOTE: PLEASE COMPLETE ELECTRONIC VERSION, PRINT AND FAX .... Handwritten forms will not be accepted.

PATIENT INFORMATION

Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)

Preferred Location* ☐ Mattoon ☐ Effingham

*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.

Diagnosis and ICD 10 CODE

☐ Multiple Sclerosis (MS) Exacerbation ICD 10 Code: G35

☐ Other: _____ ICD 10 Code: _____

REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)

☐ This signed order form by the provider

☐ Patient demographics AND insurance information

*Patient may be required to submit a pregnancy test prior to treatment

☐ Clinical/Progress notes (must be within 1 year)

☐ Labs and Tests supporting primary diagnosis

MEDICATION ORDERS

Dosing Wt for Calculations Ht: Wt (in kg): BMI:

Dosing

☐ J2919 Methylprednisolone 1 gm IV every day for a total of 5 doses

☐ J2919 Methylprednisolone 1 gm IV _____

☐ Other: _____

Duration ☐ X 6 months ☐ X 1 year ☐ _____ doses

ADDITIONAL ORDERS / INFORMATION

PRESCRIBER INFORMATION

Prescriber name :		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date: Time:

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Contact us with questions at:
Fax Completed Form and all documentation to:

☐ MATTOON
1000 Health Center Dr. Suite 204 Mattoon, IL 61938
Ph. 217-258-4150 Fax 217-348-2579

☐ EFFINGHAM
901 Medical Park Dr. Suite 201 Effingham, IL 62401
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