

LAWRENCE COUNTY
Memorial  Hospital
DEACONESS ILLINOIS PARTNER

| PATIENT INFORMATION | | |
|---|--|---------------|
| Name: | DOB: | |
| Allergies: | Date of Referral: | |
| REFERRAL STATUS | | |
| <input type="checkbox"/> New Referral <input type="checkbox"/> Dose or Frequency Change <input type="checkbox"/> Order Renewal | | |
| DIAGNOSIS AND ICDE 10 CODE | | |
| <input type="checkbox"/> Multiple Sclerosis (MS) Exacerbation | ICD 10 Code: G35 | |
| <input type="checkbox"/> Other: _____ | ICD 10 Code: _____ | |
| REQUIRED DOCUMENTATION (referral will not be processed without the required documentation) | | |
| <input type="checkbox"/> The signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance information <input type="checkbox"/> Prior authorization with reference number | <input type="checkbox"/> Clinical/Progress notes (must be within 1 year) <input type="checkbox"/> Labs and tests supporting primary diagnosis <small>*Pt may be required to submit a pregnancy test prior to treatment</small> | |
| MEDICATION ORDERS | | |
| Dosing Wt for Calculation: HT: _____ WT (kg): _____ BMI: _____ | | |
| Dosing | <input type="checkbox"/> J2919 Methylprednisolone 1gm IV every day for a total of 5 doses <input type="checkbox"/> J2919 Methylprednisolone 1gm IV _____ <input type="checkbox"/> Other: _____ | |
| Duration: <input type="checkbox"/> x6 months <input type="checkbox"/> x 1 year <input type="checkbox"/> x _____ doses | | |
| ADDITIONAL ORDERS/INFORMATION | | |
| | | |
| | | |
| | | |
| PRESCRIBER INFORMATION | | |
| Provider Name: | | |
| Office Phone: | Office Fax: | Office Email: |
| Prescriber Signature: | Date: | Time: |

ALL INFORMATION COUNTAINED IN THIS ORDER FORM IS STRICTLY CONFIDENTIAL AND WILL BECOME PART OF THE PATIENTS MEDICAL RECORD.

CONTACT US WITH QUESTIONS AT 618-943-8515
 FAX COMPLETED FORM AND ALL DOCUMENTS TO 618-943-7242

INFUSION ORDERS – METHYLPREDNISOLONE