Tysabri Referral Form

Phone 405.548.4848 **Toll Free** 888.848.4588 **Fax** 405.418.4442

PATIENT INFORMATION

Patient Name:	Date of Referral:	
Address:	SSN:	Gender:
City, State:	DOB:	Age:
Zip:	Primary Language:	
Phone:	Work Phone:	
Emergency Contact:	Relation:	Phone:
Caregiver Name (if other):	Relation:	Phone:
Primary Insurance Subscriber:		
Ins. Phone:	Group #:	Policy #:

PRIMARY DIAGNOSIS

☐ 340.0 - Multiple Sclerosis

☐ Other - Please indicate ICD9-CM code & description below.

Are you enrolled in the Tysabri Touch Program?
☐ Yes ☐ No

MEDICAL HISTORY

Patient Allergies ☐ NKDA If yes, listed:	Ht: ☐ in ☐ cm	Please Attach & Fax 1. Insurance Card(s) and Demographic Information 2. Recent Clinical Assessment Note or H&P 3. Current Medication List
	Date Taken:	
Other Medical History:		
	Wt: ☐ lbs ☐ kg	
	Date Taken:	

PRESCRIPTION ORDERS

☐ Tysabri 300mg IV over 1hr every 4 wks ☐ Sodium Chloride 0.9% 100ml administer to KVO for 1hr following Tysabri infusion	Length of Therapy:

IV CATHETER CARE:

- Dressing changes PRN
- Antimicrobial disk PRN
- Cathflo 2mg IV to each lumen PRN occlusion
- Heparin and saline flush per OptionOne protocol
- Lab draws from urine

Adverse and Anaphylactic Reactions will be treated per OptionOne protocol.

PHYSICIAN INFORMATION

Name:	Hospital/Clinic:	
Address:	Office Contact:	
City, State, Zip:	Phone:	Fax:
License #:	UPIN:	NPI:

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Signature: ____________________

Date: ____________________