PRINT

Phone: (855) 379-4250
Fax: (225) 243-7957

HaloCare
Compassionate Care, Divine Service

Neurology Referral Form

Last Name _____ First _____ DOB (mm/dd/yyyy) _____
Address _____ City _____ State, ZIP _____
Social Security # _____ Is patient age 18 or older? □ Yes □ No □ F □ M
Home Phone: _____ If no, parent/legal guardian name: _____
Cell Phone: _____ Work Phone: _____ Email: _____
Emergency contact name _____ Phone: _____

Primary Insurance Name _____ Policy # _____ Group # _____
Policy Holder Name _____ DOB _____ Insurance Phone # _____
Rx Group Number _____ Bin # _____ PCN # _____

Diagnosis: □ Multiple Sclerosis (340.0) □ Other _____
Prior med(s) _____ DC Reason: _____ Length of treatment: _____
_____ DC Reason: _____ Length of treatment: _____
_____ DC Reason: _____ Length of treatment: _____
□ NKDA Allergies: _____

Avonex ☐ 30 mcg PFS ☐ 30 mcg vial ☐ Once a week □ Other:
Betaseron ☐ 0.3 mg PFS ☐ Initial: Wk 1 & 2: 0.25ml (0.0625 mg) Week 3 & 4: 0.5ml (0.125mg)
□ q o d Week 5&6: 0.075ml (0.1875mg) Week 7+: 1 ml(0.25 mg)
□ MaintenanceL 1 ml (.025mg(every other day

Botox □ 100mg vial □ 200mg vial

Copaxone □ 20mg PFS □ SQ once a day □ Other:
Extavia 0.3mg kit □ 0.25 SQ every other day

Gilenya 0.5mg cap □ once daily □

Rebif □ Titration Pack □ 22mcg PFS □ 44 mcg PFS □ three times a week
□ Week 1&2: 0.2ml (8.8g), week 3&4: 0.5ml (22mcg) □ 0.5ml (22mcg) □ 0.5ml (44mcg)

Epipen □ 2 pack □ Inject 1 pen into thigh in case of anaphylaxis ☐ _____
Epipen Jr □ 2 pack □ Inject 1 pen into thigh in case of anaphylaxis ☐ _____
Other: _____
Directions: _____ _____
Dispense Quantity: _____ □ 1 month supply Refills: _____

Physician Name _____ NPI # _____ DEA# _____
Address _____ City/State _____ _____ ZIP _____
Phone ( ) _____ Fax # ( ) _____ Office Contact _____
Date: _____
Physician Signature: _____ No stamps please _____

Dispense as written Substitution Allowed