MICHIGAN INSTITUTE FOR NEUROLOGICAL DISORDERS (MIND)

INFUSION TREATMENT REFERRAL FORM

Infusion Center Locations: CHECK ONE:

☐ **MIND Farmington Hills**
28595 Orchard Lake Rd
Farmington Hills, MI 48334

☐ **MIND Roseville**
25100 Kelly Road
Roseville, MI 48066

Main telephone Number: 248.553.0010
Fax Number: 248.553.6217
www.mindonline.com

Patient Name: _____ Date of birth: _____

Patient Address: _____ Phone Number: _____

Allergies: _____

TYSABRI (NATALIZUMAB)

Please mark diagnosis: ☐ Multiple Sclerosis/ (ICD-10 Code: _____)
Please Include:
☐ Copy of Insurance card(s) (front and back)
☐ Copy of Driver's License (front and back)
☐ Clinical progress notes/labs/tests supporting primary diagnosis
☐ Current History and Physical with updated medication list included
☐ Most recent MRI
☐ Patient **TOUCH** Authorization
JCV Antibody Status: ☐ Positive _____ ☐ Negative _____ Date: _____
Date of Last MS treatment: Type: _____ Dose: _____Date: _____

Infusion Orders: (Annual order renewal needed):
Standard Interval dosing: ☐ 300mg IV, then every 28 days (4 weeks)
OR

Extended Interval dosing: 300mg IV every ☐ 5 weeks ☐ 6 weeks ☐ 7 weeks ☐ 8 weeks
Pre-medications: ☐ Tylenol 1000mg PO ☐ Solumedrol 40mg IVP ☐ Claritin 10mg PO
☐ Toradol 30mg IVP ☐ Benadryl 25mg PO
Additional Orders: _____

By signing this form and utilizing our services, you are authorizing MIND and its employees to serve as your prior authorization and pharmacy designated agent in dealing with medical and prescribing companies.

Physician Name: _____

Physician Signature: _____ Date: _____
Phone number: _____ Fax Number: _____

Additional Services available at MIND
Mark needed services and a MIND representative will reach out for further information
☐ **MRI** ☐ **EEG** ☐ **EMG** ☐ **OCT**