

**Patient information**

Patient name \_\_\_\_\_

DOB \_\_\_\_\_

Mobile number \_\_\_\_\_

Weight \_\_\_\_\_  kgs  lbs

**Diagnosis**

Alzheimer's disease with early onset (g30.0)  
 Alzheimer's disease with late onset (g30.1)  
 Other alzheimer's disease (g30.8)  
 Alzheimer's disease unspecified (g30.9)  
 Other \_\_\_\_\_

**Allergies**  NKDA  \_\_\_\_\_

**Medication instructions**

**Pre-medications**  N/A  
 Provider prescribed: \_\_\_\_\_

**Medication order**

<b>Dose</b>	<b>Frequency</b>
<input type="checkbox"/> Day 1: 350 mg; day 2 (4 weeks later): 700 mg; day 3 (4 weeks later): 1050 mg; day 4 and every 4 weeks 1400 mg	<input type="checkbox"/> Every 4 weeks (after initial x3 step dosing infusions)
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____

**Medication route**  IV  
 Other \_\_\_\_\_

**Lab order**  
(Include frequency) Please list any labs to be drawn by the infusion clinic:  
 N/A  
 \_\_\_\_\_

**Prerequisites** Please include the following with your fax submission: Labs and tests supporting diagnosis | Office / progress notes | Demographics | Baseline MRI within 1 year, with repeat mris needed prior to the 2nd, 3rd, 4th, and 7th infusion

**Please send to**  Columbia, MD  Silver Spring, MD  Bowie, MD  Frederick, MD

**Referring provider information**

Referring provider name \_\_\_\_\_ NPI \_\_\_\_\_

Practice name \_\_\_\_\_

Point of contact Name \_\_\_\_\_ Email \_\_\_\_\_ Phone \_\_\_\_\_

Provider signature \_\_\_\_\_ Date \_\_\_\_\_