SPRINGSIDE INFUSION

Rystiggo

Patient information

Patient name _____ **DOB** _____

Mobile number _____ **Weight** _____ ☐ kgs ☐ lbs

Diagnosis
☐ Myasthenia gravis (without acute exacerbation) (g70.00)
☐ Other _____

Allergies ☐ NKDA ☐ _____

Medication instructions

Pre-medications
☐ N/A
☐ Provider prescribed: _____

Medication order

Dose
☐ Less than 50 kg = 420 mg/3 mL
☐ 51–99 kg = 560 mg/4 mL
☐ Greater than 100 kg = 840 mg/6 mL
☐ Other _____

Frequency
☐ Once a week every 6 weeks
☐ Other _____

Medication route
☐ Subcutaneous injection
☐ 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

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 _____