

### Patient information

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

DOB \_\_\_\_\_

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

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

Diagnosis  Relapsing-remitting multiple sclerosis, ICD 10: g35.a  
 Active secondary progressive multiple sclerosis (spms), ICD 10: g35.c1  
 Clinically isolated syndrome (cis), ICD 10: g36.9  
 Other \_\_\_\_\_

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

### Medication instructions

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

Medication order Dose Frequency  
 300mg  Every 4 weeks  
 Other \_\_\_\_\_  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 | Touch portal enrollment

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 \_\_\_\_\_