vitalcare® of the FOUR STATES

NEUROLOGY ORDER FORM

Vital Care of the Four States, 109 E Hickory St., Neosho, MO 64850
OFFICE 417-451-7900 / FAX 417-451-7915

DEMOGRAPHICS

Patient Name: _____

Address: _____

City: _____ State: ____ Zip:_____

DOB: ____/____/____ ☐ Male ☐ Female

Phone: _____

SSN: _____ Ht: _____ Wt: _____

PRESCRIBING PHYSICIAN

Name: _____

Address: _____

City: _____State: _____ Zip: _____

Phone: _____ Fax: _____

License#: _____

DEA#: _____NPI: _____

ALLERGIES / REACTIONS

_____

_____

Signature: _____

Date: _____

PHYSICIAN ORDERS

☑ **RYSTIGGO** **REFILLS: _____**

☐ **<50KG = 420mg** ☐ **50-100kg = 560mg** ☐ **>100kg = 840 mg**

Infuse weekly x 6 doses every ---- Repeat cycle every _____ weeks

☐ **PRE-MEDICATIONS / LABS** **REFILLS: _____**

- ☐ Diphenhydramine 25 MG IV 15-30 minutes before infusion
- ☐ Solu-Medrol _____ MG IV — 30 minutes before infusion
- ☐ OTHER: _____
- ☐ LABS: _____

☑ **Anaphylaxis Kit per Pharmacy protocol**

TO BE ADMINISTERED BY THE HEALTH CARE PROVIDER **PRN** FOR PATIENTS RECEIVING IV MEDS IN THE HOME

Epinephrine Auto Injector 0.3mg/0.3ml IM – Repeat one time in 20 minutes if needed

ACCESS / MAINTENANCE:

☑ Subcutaneous infusion set with syringe pump at 20ml/hr per healthcare provider

DIAGNOSIS:

☐ **G70.00 Myasthenia Gravis without acute exacerbation**

☐ _____