



Select location:

- | | | | |
|------------------------|---------------------------|--------------------|-----------------------|
| Akron | Cleveland (Mayfield) | Dayton (Englewood) | |
| Anderson | Cleveland (North Olmsted) | Findlay | |
| Athens | Columbus (East Broad) | Liberty | |
| Canton | Columbus (Hilliard) | Mansfield | Toledo |
| Cincinnati (Blue Ash) | Columbus (Worthington) | Perrysburg | Warren |
| Cincinnati (West Side) | Dayton (Beavercreek) | Springfield | Crestview Hills (NKY) |

For new referrals, please include recent labs and last two office visit notes.

Fax completed form to 888-977-0914

Phone: 877-787-8720 • www.horizoninfusions.com

1. PATIENT INFORMATION

Name:		DOB:	
Phone:		Other Phone:	
Email:			
Social Security #:		Allergies:	
Gender:	M F	Weight:	Lbs Kg
Patient Status:	New to therapy Continuing therapy	Next due date (if applicable):	

2. INSURANCE INFORMATION (required)

Please submit copies of the front and back of primary and/or secondary insurance cards with this referral.

3. PHYSICIAN INFORMATION

Physician Name:		NPI#:	
License #:	TIN#:	DEA#:	
Address:			
City:		State	Zip
Office Contact:		Email:	
Office phone:		Office fax:	

4. PRIMARY AND SECONDARY DIAGNOSIS INFORMATION (ICD 10 Code Required)

Primary Diagnosis	Secondary Diagnosis	G30.8 Other Alzheimer's disease
Z00.6 Encounter for examination for normal comparison and control in clinical research program	G30.0 Alzheimer's disease w/early onset G30.1 Alzheimer's disease w/late onset	G30.9 Alzheimer's disease, unspecified G31.84 Mild cognitive impairment, unknown etiology

5. PRESCRIPTION INFORMATION (requires a new order every 12 months)

Referring provider is responsible for obtaining an MRI prior to infusion #1, #5, #7 and #14.

Administer 10 mg/kg IV over 1 hour Q2 weeks

CMS Registry Letter Received and Attached
Yes No

Registry Trial Number: _____

Vital signs per HI Protocol

Anaphylaxis & Hydration Management per HI Protocol

PRE-MEDICATIONS	N/A
Acetaminophen	500mg 650mg 1000mg
Fexofenadine (Allegra)	180mg PO (or other non-sedating antihistamine)
Diphenhydramine (Benadryl)	25mg 50mg PO IV (requires driver)
Methylprednisolone (Solu-Medrol)	40mg 80mg 125mg IV
Prednisone _____ mg PO	
Other _____	
POST-MEDICATIONS	N/A
Acetaminophen	500mg 650mg 1000mg
Prednisone _____ mg PO	
Other _____	

6. LABS

CBC w/Diff	Each Infusion	Other Frequency (specify): _____
CRP	Each Infusion	Other Frequency (specify): _____
CMP	Each Infusion	Other Frequency (specify): _____
ESR	Each Infusion	Other Frequency (specify): _____
Hepatic Panel	Each Infusion	Other Frequency (specify): _____
Renal Panel	Each Infusion	Other Frequency (specify): _____
Quantiferon TB Gold, annually, last completed (date): _____		
Other (specify): _____		

7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE

DATE