SOLEO HEALTH
Simplifying Complex Care

Alzheimer's Referral Form

Please send the following with clinical documentation, which includes visit, physical and history notes, plus lab results for last 3 months, to:

Phone: (844) 960-9090
Fax: (844) 276-1706
Email: alzheimers@soleohealth.com

Referral Process

1. PATIENT INFORMATION (*indicates a required field)

Name*: _____

Address*: _____

City*: _____ State*: _____ Zip*: _____

Home Phone: _____ Mobile Phone*: _____

Email*: _____

Primary language*: _____

DOB*: _____

Gender*: ☐ M ☐ F Height*: _____ Weight*: _____

2. PRESCRIBER INFORMATION (*indicates a required field)

Prescriber's name*: _____

NPI #*: _____

Email*: _____

Address*: _____

City*: _____ State*: _____ Zip*: _____

Phone*: _____ Fax*: _____

Specialty*: _____

Contact: _____

Allergies*: _____ NKA*: ☐

Cognitive assessment score: _____ Name of Assessment: _____ Date of assessment: _____

Labs/diagnostics attached: ☐ MRI (within 1 year) ☐ Confirmed presence of amyloid pathology (amyloid PET scan or +CSF)

3. DIAGNOSIS

*ICD10 Code: ☐ G31.84 - Mild cognitive impairment, so stated. ☐ G30.00 - Alzheimer's Disease with Early Onset.
☐ G30.1 - Alzheimer's Disease with Late Onset. ☐ G30.8 - Other Alzheimer's Disease. ☐ G30.9 - Alzheimer's Disease, unspecified.

4. INSURANCE INFORMATION

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

5. MEDICATION ORDERS Anticipated Start Date: _____

☐ **Leqembi®:** 10mg/kg IV every 2 weeks.
Refill for: ☐ 6 months ☐ 1 year Other: _____

☐ **Aduhelm®:** administer Aduhelm IV every **4 weeks** as follows. (Select One)

☐ Inital dose w/maintenance dosing.
- 1mg/kg for infusion 1 and 2
- 3mg/kg for infusion 3 and 4
- 6 mg/kg for infusion 5 and 6
- 10mg/kg for infusion 7 and beyond.

☐ Maintenance dosing only:
- 10mg/kg

Refill for: ☐ 6 months ☐ 1 year

☐ Additional Orders: _____

6. FLUSH ORDERS

Skilled nursing may insert and remove PIV, access CVC, or access/deaccess Port as needed

☐ **PIV/midline/PICC:** Flush before, after each infusion, and as needed with 3-20 mL NS, followed by Heparin 2-5 mL 10 units/mL if indicated

☐ **PORT**: Flush before, after each infusion, and as needed with 5-20 mL NS, followed by Heparin 100 unit/ml 5 mL.

7. ANAPHYLAXIS ORDERS

Adults: For mild reaction-administer diphenhydramine 50mg IVP/PO x 1.
For severe reactions-administer epinephrine 0.3mg SubQ/IM x 1. May repeat x1 if needed. Contact 911 and monitor vital signs.
If needed, repeat a second dose after 5-10 minutes for a maximum of two doses. Contact 911 and monitor vital signs

8. NURSING ORDERS: RN to assess, administer, and/or instruct patient/caregiver on medication, administration, vascular access device, disease process, signs or symptoms of adverse effects or complications of therapy. RN to establish, maintain and discontinue vascular access device. RN to draw labs as ordered via vascular access device or venipuncture.

PHYSICIAN'S SIGNATURE (required): _____ **Date:** _____