

# Infectious & Autoimmune Encephalitis (IAE) - Neuroinflammatory Disorders Referral Form

Please complete and fax the referral form to  
IAEreferrals@soleohealth.com | p: 866.288.8250 | f: 866.288.8698

| PATIENT INFORMATION   |  |  |   |               |  |
|---|--|--|---|---------------|--|
| Patient Name  |  |  | DOB   | Contact Phone |  |
| Address   |  | City   | State   | Zip           |  |
| Gender <input type="checkbox"/> M <input type="checkbox"/> F                                | Social Security, last 4 digits   |  | Weight (lb.)  | Height (in.)  |  |
| PRESCRIBER INFORMATION  |  |  |   |               |  |
| Ordering Prescriber   |  |  | Prescriber NPI  |               |  |
| Practice Name   |  |  | Phone   | Fax           |  |
| Practice Address  |  | City   | State   | Zip           |  |
| ICD 10 DIAGNOSTIC CODES AND DESCRIPTIONS (include all that apply)                           |  |  |   |               |  |
| ICD 10 Code   | Description  |  |   |               |  |
|   |  |  |   |               |  |
|   |  |  |   |               |  |
|   |  |  |   |               |  |
| REQUIRED DOCUMENTATION  |  |  |   |               |  |
| <input type="checkbox"/> Insurance Cards  | <input type="checkbox"/> HPI and Clinical Encounter Notes (if applicable, the 3 most recent) | <input type="checkbox"/> Most Recent Labs      | <input type="checkbox"/> Medication List  |               |  |
| ADDITIONAL INFORMATION (if Available from the Patient's Medical History)                    |  |  |   |               |  |
| Supportive Diagnostic Testing   |  |  |   |               |  |
| <input type="checkbox"/> CSF testing  | <input type="checkbox"/> CT (chest, abdomen, pelvis, paranasal sinus)                        | <input type="checkbox"/> ECG                   | <input type="checkbox"/> EEG  |               |  |
| <input type="checkbox"/> MRI  | <input type="checkbox"/> PET or SPECT  | <input type="checkbox"/> PSG (Polysomnography) |   |               |  |
| Blood Tests   |  |  |   |               |  |
| <input type="checkbox"/> Antinuclear Antibody Panel (ANA)                                   |  |  | <input type="checkbox"/> Immunoglobulin Quantitative: IgG, IgA, IgM   |               |  |
| <input type="checkbox"/> Anti-Streptolysin O (ASO)  |  |  | <input type="checkbox"/> Lymphocyte subset panel (both absolute and percentages) CD3, CD4, CD8, CD19 and CD56 |               |  |
| <input type="checkbox"/> Autoimmune Brain Panel (formally known as the Cunningham Panel)    |  |  | <input type="checkbox"/> Serologic testing for infectious causes (Bacteria, Viruses, Parasites)               |               |  |
| <input type="checkbox"/> CBC, CMP   |  |  | <input type="checkbox"/> Serum testing for antibodies associated with autoimmune encephalitis                 |               |  |
| <input type="checkbox"/> Erythrocyte Sedimentation Rate (ESR), C-reactive protein, Ferritin |  |  | <input type="checkbox"/> Streptococcus Pneumonia Antibody   |               |  |
| <input type="checkbox"/> Immunoglobulin (IgG) subclass panel (1-4)                          |  |  | <input type="checkbox"/> Thyroid peroxidase (TPO) and Thyroglobulin (Tg) Antibody test                        |               |  |
| <input type="checkbox"/> Neurocognitive Tests   |  |  |   |               |  |
| <input type="checkbox"/> Assessments, Scales, Questionnaires                                |  |  |   |               |  |
| <input type="checkbox"/> Other  |  |  |   |               |  |

## TREATMENT PLAN

### IMMUNOGLOBULIN

The Pharmacy will select the product based on clinical indication, product availability and payor requirements.

Administration Route    IV    SCIG    Allow rounding to the nearest 5 gram vial size  
Loading   gm/kg x   days  
Maintenance   gm/kg x   days, every   weeks

**OTHER TREATMENTS**   Include dosage, brand preference, frequency, and any other special instructions

## PREMEDICATION

- NaCL 0.9% (IV prior to IG)
- NaCL 0.9% (IV post IG)
- Dexamethasone IV
- Methylprednisolone IV

Dispense as written Substitution Permitted

- Emla cream (or generic equivalent)  
PRN for peripheral IV or port
- Ondansetron, orally disengaging tablet (ODT)
- OTHER:

## NURSING

Skilled RN to establish and maintain vascular access as needed, draw ordered labs, conduct patient assessments, and educate on home infusion, medication administration, self-monitoring and safety.

The Pharmacy may contact the prescriber to comply with state-specific requirements. The prescriber is required to comply with any applicable state-specific prescription requirements (e.g., e-prescribing, prescription forms).

The information in this form is intended only for the person(s) or entity to which it is addressed and may contain confidential or legally protected material. If you receive this information in error, please contact the sender and destroy the document(s) promptly at the direction of the sender.