Botulinum Toxin Referral Form

GAMMA THERAPEUTIC CENTER
Center for Neurological Disorders

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Greenfield, WI 53228
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Fax: (414) 763-0063
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Patient Information	
Patient Name:	Patient DOB:

Referral
☐ Referral for consideration of treatment with Botulinum Toxin

Diagnosis and ICD 10 Code	
☐ Blepharospasm	ICD 10 Code:
☐ Chronic Migraine Headache	ICD 10 Code:
☐ Hyperhidrosis	ICD 10 Code:
☐ Sialorrhea	ICD 10 Code:
☐ Spasticity	ICD 10 Code:
☐ Torticollis (Cervical Dystonia)	ICD 10 Code:
☐ Other Diagnosis:	ICD 10 Code:

Required Documentation	
☐ Patient demographics	☐ Clinical/Progress notes supporting primary diagnosis
☐ Copy of patient insurance card(s) – front & back	☐ Tried and Failed therapies

Notes (Additional Info)

Premedication, adverse and anaphylactic reactions and post injection will be treated per Gamma Therapeutic Center protocol.

Referring Provider Information		
Referring Provider Name:		NPI #:
Office Contact:	Office Phone:	Office Fax:
Referring Provider Signature:		Date: (Referral valid for 180 Days)

My signature for this referral form also confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize Gamma Therapeutic Center and Center for Neurological Disorders, S.C. and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide infusion-related nursing services and supplies in conjunction with the therapy prescribed above.

Notify patient we will contact the patient and schedule their treatment once our benefit investigation and any prior authorizations have been completed.

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