Hello, my name is ________________ and I suffer from MOG-Antibody Associated Disease (MOG-AD) which also causes me to have the following symptoms: __________________________________. MOG-AD is a neuroimmune disorder which causes my immune system to attack my central nervous system which includes the brain, spine, and optic nerves. This can cause multiple symptoms depending on where the attack is located. I regularly see my doctor, ________________________ for my illness.

Patient Information

Patient Name: ______________________________________ Date of birth: ________________________

Address: ____ Phone: ______________________________

Insurance Plan: ____________________ Insurance Group ID: _____________________ Insurance ID:

EMERGENCY CONTACT

Name: _____________________________ Relationship: ___________ Phone:_________________________

Check boxes below that apply:

☐ I have an advance directive. ☐ I have a Power of attorney.

If the Advance directive recipient or Power of Attorney is different from above, please place contact information below.

Name: _________________________ Relationship: ___________ Phone:

DOCTOR CONTACT

In the event of a relapse please contact my (check one below that applies to you) for additional information regarding treatment plan.

☐ PCP ☐ Neurologist ☐ Ophthalmologist Other specialty: _____________________

Doctor's Name: _______________________ Practice Name: ______________________

Phone Number: _________________________ Email: ____________________________

My doctor told me to seek immediate medical attention if I experience any of the following symptoms:

____

____

____

If my doctor is unable to be reached immediately, please contact your on-call neurologist about the plan my doctor discussed with me during relapse. My doctors plan is to start me on the medication ______________ at the dosage of _________________ for the duration of _________________, until he can be reached.

______________________________ _____________________

(Doctors signature) Date of Approval

ADDITIONAL MEDICAL HISTORY

Additional Medical History:____

____

____

Current Medication(s) :____

____

____

Allergies: ____

____

____

These are guidelines, not medical orders.