AK/017/CND

Republic of Lebanon
Ministry of Public Health
Catastrophic Illnesses Medical Committee

الجمهورية اللبنانية
وزارة الصحة العامة
لجنة الأمراض المستعصية

Nervous System Medications

رقم المعاملة

Patient Information

اسم المريض الثلاثي: ----------تاريخ الولادة: -----/----/------- ذكر ☐ انثى ☐

المحافظة والقضاء : ---------- البلدة : ----------الشارع : ---------- ملك : ----------هاتف : ----/----------

- **Detailed medical report and prescription. (**For all patients under 18 years: weight ------- Kg**).**
- **This application is: ☐a NEW application v/s ☐ an application for RENEWAL**
- **Please select the diagnosis:**

☐	**Epilepsy (G40)** ☐Generalized epilepsy **OR** ☐Partial-onset epilepsy (submit EEG and/or MRI)
☐	**Parkinson Disease (G20)**
☐	**Dementia (F03):** ☐ Mini mental status examination (MMSE)
☐	**Multiple sclerosis (G35):** Select type ☐ Relapsing-remitting MS **OR** ☐ Primary progressive MS **For new applications only:** ☐ MRI of head or spinal cord ☐ CSF IgG index/oligoclonal bands OR ☐ Visual evoked potentials **For fingolimod (Gilenya) or natalizumab (Tysabri), please also provide for new applications only:** ☐ Medications for MS that patient failed: …….. ☐ New MRI of head with gadolinium (within the last 3 months) **For fampridine (Fampyra), please also provide results of timed 25-foot (7.6-meter) walk test:** ☐ Before starting fampridine: …… seconds ☐ One month after starting fampridine: …… seconds
☐	**Myasthenia gravis (G70.0):** Weight: ……. Kg ☐ Nerve conduction studies /electromygraphy (EMG)* with repetitive stimulation OR ☐ Anti-acetylcholine receptor antibody titer
☐	**Guillain-Barré syndrome & chronic inflammatory demyelinating polyneuropathy (G61.0):** ☐ Weight: ……... Kg ☐ Nerve conduction studies /electromyography (EMG)*
☐	**Motor neuron disease, including amyotrophic lateral sclerosis (G12.2):** ☐ Nerve conduction studies /electromyography (EMG)*
☐	**Other nervous system disorders (please specify):**

*Nerve conduction studies / electromyography (EMG) are required for new applications only

Physician Information

Physician Name: ---------- LOP Registration No: ----------

Specialty: ---------- Telephone: ----/----------

Date :---- / ---- / --------- Signature & Stamp :

N.B:

1. This form must be completed by the doctor
2. All information should be attached and must be official and original
3. اخراج قيد لا يتعدى اصداره عن ٦ اشهر مع صورة عن بطاقة الكرنتينا