RSV Prevention Center Referral Form

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LeBonheur Children's Hospital | The University of Tennessee Health Science Center

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Patient Information

Name (First, Last) _____ DOB _____ SSN _____ Birth Wt_____
Address _____ City _____ State _____ Zip _____
Primary Guardian _____ Secondary Guardian _____
Primary Phone # _____ Secondary Phone # _____
Patient one of multiple births? ☒Yes ☐No / If yes, is sibling(s) referral being submitted simultaneously? ☐Yes ☒No
Sibling name(s)_____

Insurance Information

☐No Insurance ☐Copy of Front and Back of Medical and/or Pharmacy Card Included

	Primary Insurance	Secondary Insurance	Pharmacy Benefit
Insurance Name			
Cardholder Name (if not patient)/DOB			
Group Number			
Policy Number			
Insurance Phone #			
BIN #	N/A	N/A	

Independent Practice Association (IPA) / Accountable Care Organization (ACO) (if applicable):

Prescriber Information	Treating	Referring
Provider Name		
Site Name		
Site Address (Street/City/State/ZIP)		
Telephone # / Fax #	/	
Office Contact		
NPI #		N/A
License # / Tax ID #	/	N/A
Medicaid Provider # / DEA #	/	N/A

Diagnosis

Patient's gestational age (GA)_____ **Current weight**_____**kg** _____ **lbs-oz** **Date current weight recorded** _____
PRIMARY: ICD-9 _____ **or ICD-10** _____
SECONDARY: ICD-9 _____ **or ICD-10** _____
See fax cover sheet for common ICD-9 codes used for Synagis
CLINICAL INFORMATION: ☐**Medical records included**

1. ☐**CLDP/BPD: Diagnosis of chronic lung disease of prematurity/bronchopulmonary dysplasia and ≤24 months of age** (Specific Diagnosis Code _____)
Is patient receiving medical treatment (check all that apply and provide last date received):
☐Oxygen date: _____ ☐Corticosteroids date: _____ ☐Bronchodilators date: _____ ☐Diuretics date: _____

2. ☐**CHD: Diagnosis of hemodynamically significant congenital heart disease and ≤24 months of age** (Specific Diagnosis Code _____)
Patient has the following condition: (check all that apply)
☐Medications for CHD: _____ ☐Diagnosis of moderate to severe pulmonary hypertension
Date CHD medications were last received: _____ ☐Cyanotic CHD

3. Indicate applicable risk factors:
☐Congenital abnormality of airways ☐Severe neuromuscular disease ☐Pre-school or school-aged sibling(s) (<5 years of age)
☐Family history of asthma or wheezing ☐Residency in rural setting ☐Daycare attendance: 2 unrelated children for >4 hours/week
☐Multiple births ☐Exposure to environmental tobacco smoke or air pollutants

4. Additional information:
☐Other medical history: _____

Prescription Information

Was Synagis® (palivizumab) previously administered (NICU/hospital/other location)? ◉No ○Yes Date(s): _____
Expected date of first/next dose: _____
Deliver product to: ☐Office ☐Patient's home ☐Clinic Clinic Name and Location: _____
Agency nurse to visit home for injection? ■No ☐Yes Agency name and Tax ID number: _____

Required ★

Rx ☐Synagis® (palivizumab) 50 mg and/or 100 mg vials. Inject 15 mg/kg IM one time per month. QS to achieve 15 mg/kg dose. **Refills:** _____
☐Epinephrine 1:1000 amp. Sig: Inject 0.01 mg/kg IM/SC as directed
☐Known allergies: _____ ☐Ancillary supplies and kits as needed for administration: _____

Required ★

Original signature of prescriber_____ **Date** _____