



FAX: (901) 387-5149

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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 _____