



Location

Liverpool
New Hartford

For new referrals, please include recent labs and last two office visit notes.

Fax completed form to (315) 457-4305

1. PATIENT INFORMATION

Name:		DOB:	
Phone:		Other Phone:	
Email:			
Social Security #:		Allergies:	
Gender:	M	F	Weight:
		Lbs	Kg
Patient Status: New to therapy Continuing therapy Next due date (if applicable):			

2. INSURANCE INFORMATION (required)

Please submit copies of the front and back of primary and/or secondary insurance cards with this referral.

3. PHYSICIAN INFORMATION

Physician Name:		NPI#:	
License #:	TIN#:	DEA#:	
Address:			
City:		State	Zip
Office Contact:		Email:	
Office phone:		Office fax:	

4. DIAGNOSIS INFORMATION (ICD 10 Code Required)

Paroxysmal nocturnal hemoglobinuria (_____)	Meningococcal Vaccination	Other: _____
Atypical hemolytic uremic syndrome (_____)	Status & Date _____	
gMG/AChR antibody + (_____)	NMOSD/AQP4 antibody + (_____)	

5. PRESCRIPTION INFORMATION (requires new order every 12 months)

Initial	PRE-MEDICATIONS	N/A
Administer _____ mg Q _____ week(s) IV	Acetaminophen	500mg 650mg 1000mg
Maintenance	Fexofenadine (Allegra)	180mg PO (or other non-sedating antihistamine)
Administer _____ mg Q _____ week(s) IV	Diphenhydramine (Benadryl)	25mg 50mg PO IV (requires driver)
Vital signs per HI Protocol	Methylprednisolone (Solu-Medrol)	40mg 80mg 125mg IV
Anaphylaxis & Hydration Management per HI Protocol	Prednisone _____ mg PO	
	Other _____	
	POST-MEDICATIONS	N/A
	Acetaminophen	500mg 650mg 1000mg
	Prednisone _____ mg PO	
	Other _____	

6. LABS

CBC w/Diff	Each Infusion	Other Frequency (specify): _____
CRP	Each Infusion	Other Frequency (specify): _____
CMP	Each Infusion	Other Frequency (specify): _____
ESR	Each Infusion	Other Frequency (specify): _____
Hepatic Panel	Each Infusion	Other Frequency (specify): _____
Renal Panel	Each Infusion	Other Frequency (specify): _____
Quantiferon TB Gold, annually, last completed (date): _____		
Other (specify): _____		

7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE

DATE