

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

Fax completed form to (315) 457-4305

Phone (315) 457-3091

1. PATIENT INFORMATION

Name:		DOB:	
Phone:		Other Phone:	
Email:			
Social Security #:		Allergies:	
Gender:	M F	Weight:	Lbs Kg
Patient Status:		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)

Emphysema () Alpha Antitrypsin Deficiency () Other: _____

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

ARALAST	GLASSIA	PRE-MEDICATIONS	N/A
Administer 60mg/kg IV once per week		Acetaminophen	500mg 650mg 1000mg
		Fexofenadine (Allegra)	180mg PO (or other non-sedating antihistamine)
PROLASTIN-C		Diphenhydramine (Benadryl)	25mg 50mg PO IV (requires driver)
Administer 60mg/kg (+/- 10%) IV once per week		Methylprednisolone (Solu-Medrol)	40mg 80mg 125mg IV
		Prednisone	_____ mg PO
Vital signs per HI Protocol		Other	_____
Anaphylaxis & Hydration Management per HI Protocol		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