



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: 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 () Myasthenia Gravis ()
Atypical hemolytic uremic syndrome () Other: _____

***Meningococcal Vaccination Status & Date (must be at least 2 weeks prior to 1st dose)** _____

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

Initial Maintenance

Administer _____ mg IV every _____ weeks
Followed by _____ mg IV every _____ weeks
Then _____ mg IV every _____ weeks
Infuse at _____

Vital signs per HI Protocol
Anaphylaxis & Hydration Management per HI Protocol

PRE-MEDICATIONS N/A

Acetaminophen 500mg 650mg 1000mg
Fexofenadine (Allegra) 180mg PO (or other non-sedating antihistamine)
Diphenhydramine (Benadryl) 25mg 50mg PO IV (requires driver)
Methylprednisolone (Solu-Medrol) 40mg 80mg 125mg IV
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