SYNAGIS REFERRAL FORM

ADVANCED PHARMACY and RESPIRATORY CARE SOLUTIONS

Fax Form to: 949-582-6111

Any questions, call intake: 800-464-7736 ext: 3

Today's date: ____/____/____

Patient Name: _____

Address: _____ Insurance Company: _____

City/State/Zip: _____ Group/Policy #: _____

Phone (day): _____ Insurance Phone #: _____

Phone (night): _____ Mother's Name: _____

Gender: ☐ Male ☐ Female DOB:____/____/____ ☐ English ☐ Spanish ☐ Other _____

Statement of Medical Necessity: **Current Weight (kg):** _____

Gestational Age at Birth (weeks & days): _____ **Date Taken:** _____ **Birth Weight (kg):** _____

Please include current Medical Notes or Discharge Summary for patient.

☐ Prematurity gestational age of **<28 weeks, 6 days**-AND less than **12 months** at the start of season.

☐ **Chronic Lung Disease** (CLD/BPD) of prematurity, during the **1st year** of life. Defined as gestational age less than 32 weeks 0 days and a requirement of more than 21% oxygen for at least the first 28 days of birth.

☐ **Chronic Lung Disease (**CLD/BPD) during the **2nd year** of life defined as above and continue to require medical therapy within 6 months before start of second RSV season.

☐ Continuous oxygen/date: ☐ Diuretics/date:
☐ Corticosteroids/date: ☐ Bronchodilators/date:
☐ >21% Oxygen for at least 28 days after birth:
(check all that apply)

☐ **Congenital heart disease** (CHD) in **1st year** of life, born within 12 months of the RSV season and hemodynamically significant .
(check all that apply)

☐ Cyanotic heart disease: ☐ Acyanotic heart disease:
☐ Surgery to correct CHD: Date of Surgery: _____ (Date of Surgery or Date to be done)
☐ Moderate/severe pulmonary hypertension:
☐ Medication to control CHD: _____ Start Date: _____ (Please list medication)

☐ Congenital heart disease (CHD) and **younger than 24 months** who undergoes cardiac transplant, bypass surgery or extracorporeal membrane oxygenation during the RSV season. Date of Surgery: _____

☐ Compromised handling of secretions due to significant abnormalities of airways/neuromuscular condition and <12 months at start of RSV season.

☐ Profoundly immune compromised, <24 months during RSV SEASON.

☐ Retinophy of Prematurity, provide notes.

☐ Other: _____

☐ School aged siblings Ages: ☐ Day Care Attendance :

PRESCRIPTION:

☐ **Rx: SYNAGIS- 15mg per kg, IM, Q 28-30 days X _____ Months** **Last Synagis Injection given: ____/____/____**

☐ **Rx: EPINEPHRINE- 1:1000 amp inject 0.01mg/kg SQ, for anaphylaxis.** **NICU History** ☐ **Yes** ☐ **No**
(for doses to be injected @ the home) **Dispensed 1x with 1st dose.** **Was first dose given in NICU** ☐ **Yes** ☐ **No**

Please CHECK one: INJECTION to be given by the: ☐ **HOMEHEALTH CARE NURSE OR** ☐ **MD/CLINIC/OFFICE**

Office Contact & E-mail: _____

PRINT Doctor Name: _____ Phone # : _____

Hospital/Clinic Affiliation: _____ Office Fax: _____

Doctor's Address: _____ City: _____ State/Zip: _____

Doctor's NPI #: _____ California License# _____

Doctor's Signature: _____ **M.D.** DATE:___/___/___

CCS Paneled Specialist Co-Signature (if prescribing MD is not): _____

Print CCS MD name: _____

Primary Care Physician: (If not same as above)

Physician's Name: _____ **Office Contact & E-mail:** _____

Hospital/Clinic Affiliation: _____ Phone #: _____

Address: _____ Fax #: _____

City/State/Zip: _____ License #: _____ NPI #: _____