

# SYNAGIS REFERRAL FORM

## 2011-2012 SEASON ADVANCED PHARMACY and RESPIRATORY CARE SOLUTIONS

Fax Form to: 949-582-6111

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

Today's date: \_\_\_/\_\_\_/\_\_\_  
Referred by: \_\_\_\_\_  
Phone No. \_\_\_\_\_  
Fax No. \_\_\_\_\_

Patient Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Phone (day): \_\_\_\_\_  
Phone (night): \_\_\_\_\_  
Current Age (months): \_\_\_\_\_  
Current Weight (kg): \_\_\_\_\_ Date Taken: \_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_ Sex: M  F   
Insurance Company: \_\_\_\_\_  
Group/Policy #: \_\_\_\_\_  
Insurance Phone #: \_\_\_\_\_  
Mother's Name: \_\_\_\_\_  
Mother's SSN: \_\_\_\_\_  
Mother's Birth Date: \_\_\_\_\_

### Statement of Medical Necessity

#### Primary Diagnosis:

Gestational Age of Birth (weeks): \_\_\_\_\_  
Birth Weight (kg): \_\_\_\_\_  
Low Birth Weight (<2500 grams): YES  NO

English  Spanish  Other \_\_\_\_\_   
Chronic Lung Disease? YES  NO   
Congenital Heart Disease? YES  NO   
Congenital Abnormalities of the Airway? YES  NO   
Neuromuscular Disease? YES  NO   
Cystic Fibrosis? YES  NO

Please include current Medical Notes or Discharge Summary for all patients.

### CHECK APPROPRIATE DIAGNOSIS:

- 765.2 Gestational Age less than 28 weeks, less than 1 year of age at onset of RSV season.
- 765.2 Gestational Age 29 - 31.6 weeks, less than 6 months of age at onset of RSV season.
- 765.2 Gestational Age 32 - 34 weeks 6 days, and less than or equal to 90 days of age at onset of RSV season with one risk factor: attendance in daycare or siblings under the age of 5 living permanently in home.

#### Additional Risk Factors: (Check all that apply)

- Siblings under the age of 5 living permanently in the home (Medi-Cal).
- Attendance in daycare (4 or more hrs/wk w/2 or more unrelated children)
- School aged siblings in the home
- Congenital Abnormalities of the Airway
- Neuromuscular Disease
- Exposure to environmental air pollutants (tobacco smoke, wood-burning stove, etc.)
- 770.7 Chronic Respiratory Disease Prematurity of perinatal period, Bronchopulmonary Dysplasia, Interstitial Pulmonary Fibrosis, or Wilson-Mikity Syndrome
- Other (please indicate ICD9 CM Code & accurate diagnosis) \_\_\_\_\_

#### Other Risk Factors:

- Rural Setting
- Crowded living conditions
- Multiple Birth
- Family history of Asthma
- Young Chronological age (<12 weeks)

Last Synagis Injection given: \_\_\_/\_\_\_/\_\_\_

### PRESCRIPTION:

Rx: SYNAGIS- 15mg per kg, IM, Q 28-30 days X \_\_\_\_\_ Months

Rx: EPINEPHRINE- (for doses to be injected @ the home) 1:1000 amp inject 0.01mg/kg SQ, UD for anaphylaxis.

Dispensed 1x with 1st dose.

Please Check one: INJECTION to be given by the: HOMEHEALTH CARE NURSE or MD/CLINIC

Doctor: \_\_\_\_\_ Doctor's Phone # \_\_\_\_\_  
Hospital/Clinic Affiliation: \_\_\_\_\_  
Doctor's Address: \_\_\_\_\_ Office Contact: \_\_\_\_\_  
Doctor's NPI #: \_\_\_\_\_ California License# \_\_\_\_\_  
Doctor's Signature: \_\_\_\_\_ M.D. DATE: \_\_\_/\_\_\_/\_\_\_

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

### Physician Following Discharge

Physician's Name: \_\_\_\_\_  
Hospital/Clinic Affiliation: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_

Office Contact: \_\_\_\_\_  
Phone #: \_\_\_\_\_  
Fax #: \_\_\_\_\_  
License #: \_\_\_\_\_ NPI #: \_\_\_\_\_