2013-2014 SYNAGIS REFERRAL FORM

Telephone: 614-355-1100 Fax: 614-355-1111

NATIONWIDE CHILDREN'S
When your child needs a hospital, everything matters.

Section 1: Patient Information

Patient Name (Last, First MI): _____ MR#: _____ Sex (circle one) M / F

DOB: _____ SSN: _____ - _____ - _____ Parent Name(s): _____

Address: _____ City: _____ State: _____ Zip code: _____

Primary Phone Number: _____ County: _____

Secondary Phone Number: _____

Section 2: Health Insurance Information

*Copy of card if available. *If Ohio Medicaid, fill out ODJFS authorization form or NCHH will complete & request the physician signature.

Primary Insurance: _____ Secondary Insurance: _____

Policy ID Number: _____ Policy ID Number: _____

Subscriber Name: _____ Subscriber Name: _____

Group Number: _____ Group Number: _____

Section 3: Statement of Medical Necessity / Diagnosis Information

Was 1st dose received in hospital/NICU? Y / N If so, date received: _____ *See ordering information below.

Patient's Gestational Age at birth: _____ **weeks** **Birth Weight:** _____ **kg**

Prematurity: ☐ Gestational age of ≤ 28 wks & < 12 months at start of RSV season (since 11/01/12)
☐ Gestational age of 29-31 6/7 wks & ≤ 6 months at start of RSV season (since 05/01/13)
☐ Gestational age of 32-34 6/7 wks & ≤ 3 months at start of RSV & with additional risk factors (since 08/01/13)
*(**Note: 32-34 6/7 wks are only eligible for a 3 dose maximum for child up to 90 days old**)*

☐ Congenital Heart Disease (please specify): _____& ≤ 24 months at start of season (since 11/01/11)
Medications for CHD: _____
☐ Chronic Lung Disease (please specify): _____& ≤ 24 months at start of season (since 11/01/11) **OR**
☐ BPD & ≤ 24 months at start of season (since 11/01/11) & taking lated medications (since 5/01/13)
Examples: Oxygen, diuretics, steroids and/or bronchodilators _____

Additional Risk Factors (check all that apply):

☐ Low Birth Weight (<2500g) ☐ Multiple Birth ☐ Siblings < 5 years old
☐ Congenital Airway Abnormalities (specify): _____ ☐ Day care attendance
☐ Neuromuscular Disease (specify): _____ ☐ Other: _____

Section 4: Ordering Information (must be signed by physician only)

Pharmacy Order: Synagis (palivizumab) 15mg/kg IM every 28-31 days
Fill through 4/30/2014 (unless insurance dictates otherwise)
☐ Epinephrine 0.01mg/kg SQ prn anaphylaxis

Current weight: _____
Date recorded: _____
Allergies: _____

Nursing Order: Homecare to administer Synagis dose of 15mg/kg IM every 28-32 days & weight to be determined at time of visit.

☐ Date of 1st injection to be given between _____and_____ or ☐ ASAP
☐ If 1st injection given inpatient or in another setting, subsequent injection to be given every 28-31 days of previous injection date x 4-6 months
☐ No nursing required

Physician Name: _____ **Physician Signature:** _____ **Date:** _____
PRINTED **NO STAMPS**

Medicaid ID #: _____ License #: _____ DEA #: _____ NPI #: _____

Office Address: _____ City: _____ State:_____ Zip: _____

Phone #: _____ Fax #: _____ **Office Contact:** _____

Section 5: Primary Care Physician Information (if different than prescribing physician)

Primary Care Physician: _____ Phone #: _____

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