



Phone: 713-383-2100 *Option #5*
 800-866-1851 *Option #5*
 Synagis Fax: 713-383-2114
 1 866-674-2114

SYNAGIS Referral Form
 (palivizumab)

OPTION TO SUBMIT ELECTRONICALLY AT WWW.CAREGRP.COM

SYNAGIS REFERRALS MAY BE FAXED YEAR – ROUND
 Please fax a copy of patient's hospital discharge summary with this form

DEMOGRAPHICS:

Patient Name: _____ <small>(Last name) (First name)</small>		Sex: M <input type="checkbox"/> F <input type="checkbox"/>	DOB: ___ / ___ / ___
Parent / Guardian's Name: _____		Phone # (Home) _____	
Address (No P.O. Box): _____		Phone # (Work) _____	
City: _____	State: _____	Zip Code: _____	Phone # (Cell) _____
Primary Insurance: _____	Policy# _____	Group# _____	PPO <input type="checkbox"/> HMO <input type="checkbox"/> POS <input type="checkbox"/>
Phone # _____	Policyholder _____	DOB: _____	Employer _____
Secondary Insurance: _____	Policy# _____	Group# _____	PPO <input type="checkbox"/> HMO <input type="checkbox"/> POS <input type="checkbox"/>
Phone # _____	Policyholder _____	DOB: _____	Employer _____

MEDICAL HISTORY (check all that apply):

<p>Diagnosis</p> <p><input type="checkbox"/> Prematurity/ _____ weeks gestation</p> <p style="text-align: center;">Multiple births <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><input type="checkbox"/> CLD/BPD</p> <p><input type="checkbox"/> CHD – <u>Must Specify</u> Cardiac Diagnosis _____</p> <p><input type="checkbox"/> Severe Neuromuscular Disease – Diagnosis _____</p> <p><input type="checkbox"/> Immunocompromised – Diagnosis _____</p> <p><input type="checkbox"/> OTHER _____</p> <p>CURRENT MEDICAL MANAGEMENT OF RESPIRATORY CONDITION (within the last 6 months)</p> <p><input type="checkbox"/> Oxygen use <input type="checkbox"/> Steroids <input type="checkbox"/> Nebulizers <input type="checkbox"/> Bronchodilator <input type="checkbox"/> Diuretic <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Mechanical Ventilation</p> <p>CURRENT MEDICAL MANAGEMENT OF CONGENITAL HEART DISEASE</p> <p><input type="checkbox"/> Antihypertensives <input type="checkbox"/> Diuretics <input type="checkbox"/> Surgical Repair _____ (date) <input type="checkbox"/> Other</p> <p>Other Pertinent History (recent hospitalization or past RSV episodes) _____</p> <p>Birth Weight _____ Current Weight _____ kg on _____ (date)</p> <p>First Dose was given ___ / ___ / ___ at _____ (Location / Facility)</p>	<p>Risk Factors</p> <p><input type="checkbox"/> School age siblings</p> <p><input type="checkbox"/> Care outside the home/daycare</p> <p><input type="checkbox"/> Exposure to Environmental Air Pollutants</p>
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REFERRAL FORM:

Referring Physician: _____	Contact: _____
Group Name (if applicable): _____	Phone: _____ Fax: _____
Address: _____	City: _____ Zip: _____
NPI # _____	UPIN # _____ Tax ID # _____
If Referring Physician is not PCP, please list PCP	
	Phone#: _____

PHYSICIAN'S REASON FOR REFERRAL:

Administer Synagis (palivizumab) 15 mg/kg IM monthly through RSV Season	
REFERRING PHYSICIAN SIGNATURE _____ <small>(Signature Required)</small>	DATE _____
REFERRING TO <u>The Synagis Center</u>	DATE _____