

SYNAGIS REFERRAL FORM 2011-2012

****FAX COMPLETED FORM TO PEDS PULMONARY 585-275-8706****

BABY'S NAME: _____ **DATE OF BIRTH:** _____

ADDRESS: _____

PHONE #s: _____

INSURANCE: _____ **POLICY # :** _____

CARD HOLDER: _____ **RELATION TO BABY:** _____

SECONDARY INS INFO: _____

REFERRING PHYSICIAN: _____ **PHONE:** _____

(1.) Prematurity

Patient's Gestational Age: _____ wks _____ days Birth Weight: _____

Current Weight _____ kg lbs (circle one) Date Recorded _____

- Gestational age of <28 6/7 weeks and <12 months of age at the start of RSV season (dob December 1, 2010 or later)
- Gestational age of 29 0/7-31 6/7 weeks and <6 months of age at the start of RSV season (dob June 1, 2011 or later)
- Gestational age of 32 0/7 -34 6/7 weeks and <3 months of age at the start of RSV season (dob Sept 1, 2011) and at least one of the following risk factors:
 - Sibling under 5 years of age
 - Day care attendance

NICU HISTORY: Yes No Please attach the NICU Discharge Summary
Was there a NICU/HOSPITAL dose administered? Yes No Date(s): _____

- <24 MONTHS OF AGE AT START of RSV season (dob 12/1/2009 or later) and a diagnosis of 2 or 3
- <12 mos of age with diagnosis of 4

(2.) Diagnosis of chronic pulmonary disease (CLD/BPD)

- Yes Is patient receiving medical treatment of (check all that apply & provide the last date received):
- Oxygen Date: _____ Diuretics Date: _____
- Corticosteroids Date: _____ Bronchodilator Date: _____

(3.) Diagnosis of complex congenital heart disease and/or cyanotic heart disease

- Yes Indicate type of heart problem and ICD-9 diagnosis code: _____
- Diagnosis of moderate-severe pulmonary hypertension Diagnosis of congestive heart failure
- Cardiac medications: _____ Date last received: _____
- Peds Cardiology Only-please indicate MD or NP referring: _____

(4.) Diagnosis of congenital airway abnormality or severe neuromuscular weakness if <12 mos of age (dob December 1, 2010)

- Yes or compromising pulmonary disease as reviewed to meet AAP guidelines _____

