



# SHERWOOD CLINICAL

## Synagis® Referral Form

800-847-3987  
 706-776-9127  
 Fax: 706-776-9027  
 www.sherwoodclinical.com



### PATIENT INFORMATION

Name:		Medicaid:	
D.O.B.:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Insurance Co.:	
Parent/Guardian Name:		Insurance Phone #:	
Address:		Policy Holder Name:	
City, State, Zip:		Policy Holder D.O.B.:	
Phone (home):	Phone (work):	ID #:	Group #:
Emergency Contact:	Phone:	Employer:	Phone #:

### STATEMENT OF MEDICAL NECESSITY

THIS PATIENT REQUIRES INJECTIONS OF SYNAGIS® TO PREVENT R.S.V. AND TO AVOID FREQUENT HOSPITAL STAYS.

Primary Diagnosis:

Additional Risk Factors
<input type="checkbox"/> Attends day care
<input type="checkbox"/> School-aged sibling
<input type="checkbox"/> Exposure to environmental air pollutants
<input type="checkbox"/> Neuromuscular disease
<input type="checkbox"/> Congenital airway abnormalities

ACTUAL GESTATIONAL AGE: \_\_\_\_\_ (weeks) \_\_\_\_\_ (days)

BIRTH WEIGHT: \_\_\_\_\_

770.7 CHRONIC RESPIRATORY DISEASE ARISING IN THE PERINATAL PERIOD (i.e. BPD, Interstitial Pulmonary Fibrosis)

CONGENITAL HEART DISEASE (Specify actual ICD-9 Code) \_\_\_\_\_

770.0-770.9 OTHER RESPIRATORY CONDITIONS OF FETUS AND NEWBORN (Specify actual ICD-9 Code:) \_\_\_\_\_

SPECIFY TREATMENT (i.e. O<sub>2</sub> use, ventilation, bronchodilator, diuretic, corticosteroid therapy) \_\_\_\_\_

CURRENT WEIGHT: \_\_\_\_\_ DATE OBTAINED: \_\_\_\_\_

DATE OF LAST SYNAGIS® INJECTION: \_\_\_\_\_ ALLERGIES: \_\_\_\_\_

THIS PATIENT REQUIRES SPECIAL PRECAUTIONS: \_\_\_\_\_ N \_\_\_\_\_ Y IF YES, DESCRIBE: \_\_\_\_\_

### PHYSICIAN INFORMATION

Ordering Physician:	Hospital/Clinic:	
Address:	License #:	DEA #:
City, State, Zip:	NPI #:	
Office Phone #:	Office Contact:	Office Fax #:

### PRESCRIPTION

SYNAGIS® (palivizumab) human monoclonal antibody product IM Injection 15 mg/kg every 28-35 days

TO START Month \_\_\_\_\_ Year \_\_\_\_\_ TO END Month \_\_\_\_\_ Year \_\_\_\_\_

SKILLED NURSING VISIT by Sherwood Clinical nurse for each monthly injection

Will this patient need a Nebulizer? \_\_\_\_\_ Yes \_\_\_\_\_ No

Physician  
Signature:

Date: