

ASTHMA REFERRAL FORM

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List <input type="checkbox"/> NKDA <input type="checkbox"/>	City, State, Zip:
Weight: _____ lbs or _____ kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- H&P
- Patient Demographics
- Most Recent Labs
- Medication List
- Tried/Failed Therapies

For Xolair: Positive skin test or in vitro reactivity to a perennial aeroallergen? Y N Date of test: _____

PRIMARY DIAGNOSIS

<input type="checkbox"/> J45.40 Moderate persistent asthma, uncomplicated	<input type="checkbox"/> J45.901 Unspecified asthma with (acute) exacerbation
<input type="checkbox"/> J45.50 Severe persistent asthma, uncomplicated	<input type="checkbox"/> J82.83 Eosinophilic asthma
<input type="checkbox"/> J45.51 Severe persistent asthma with (acute) exacerbation	<input type="checkbox"/> Other: _____
<input type="checkbox"/> J45.901 Unspecified asthma with (acute) exacerbation	

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

Per infusion clinic protocol: No recommended standard pre-meds

Provider Prescribed: _____

PRIMARY MEDICATION ORDER

<input type="checkbox"/> Xolair _____ mg SubQ Injection every 2 weeks
<input type="checkbox"/> Xolair _____ mg SubQ Injection every 4 weeks
<input type="checkbox"/> Tezspire 210mg SubQ Injection every 4 weeks
<input type="checkbox"/> Fasenra 30mg SubQ Injection at week 0, 4, 8, and every 8 weeks thereafter
<input type="checkbox"/> Nucala 100mg SubQ Injection every 4 weeks
<input type="checkbox"/> Cinqair 3mg/kg (_____ mg) IV every 4 weeks
<input type="checkbox"/> Other: _____

First Dose: Y N Refill x12 months unless otherwise noted: _____

LINE USE/CARE ORDERS

Start PIV/ACCESS CVC Flush device per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)

Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

Administer acute infusion and anaphylaxis medications per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)

Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	<input type="checkbox"/> Fax:
NPI AND License:	<input type="checkbox"/> Email:

Provider Signature _____

Date _____