SYNAGIS REFERRAL 2015-2016	**Pediatric Diagnostic Center** **Synagis Coordinator Kay Urban** **Phone: 652-6255 Please provide insurance information. Gray mail with records (NICU records are necessary) FAX 652-3375** **Or email kay.urban@ventura.org**
Today's Date:	Referred By:
Phone #:	Fax #:
Patient Name:	Patient SSN:
DOB:	CCS #:
Parent/Caretaker Name:	Other Insurance:
Address:	Policy #:
City/State/Zip:	Ins. Phone #:
Phone:	Mothers SSN#:
Primary Care Physician:	Mother DOB:

Statement of Medical Necessity

Primary Diagnosis:

Gestational Age of Birth (Weeks):_____ Chronic Lung Disease?_____

Birth Weight (Kg): _____ On Oxygen in Last 6 months?_____

Congenital Heart Disease?_____

Diagnosis:

___ P07.2_- P07.3_Gestational Age less than 29 weeks 0 days, less than 1 year of age at onset of RSV season

___ P27.8 Chronic Lung Disease of prematurity defined as <32 weeks, 0 days gestation and a requirement for >21% oxygen for at least 28 days after birth.

___ P23.9-P28.9 Other Respiratory Conditions arising in the newborn period

___ Q20.0-Q28.9 Hemodynamically significant heart disease

___ Other (Please indicate ICD 9 Code & Accurate diagnosis)

Email of person submitting form:_____

SYNAGIS PRESCRIPTION

Rx: SYNAGIS 15mg per Kg IM. Give Q25-30 days X _____months

Current Weight: _____Kg Date of Current Weight: _____

Requesting Physician:	Physician Phone #:
Address:	
Physician DEA#	CA Lic. #
Physician Signature: M.D.	Date:

Revised 07.31.15