# SYNAGIS REFERRAL FORM

**Fax Oakland Synagis Referrals to (510) 985-2202**
**Include hospital discharge summary and/or last clinic note**

UCSF Benioff Children's Hospitals

| **PATIENT INFORMATION**<br>Patient's First Name: | Last Name: |
|---|---|
| DOB: | Gender: |
| Home Phone: | ☐Work or ☐Cell Phone: |
| Interpreter Needed? ☐yes ☐no | Language: |
| Parent/Guardian: | Relationship to Patient: |
| DOB: | Email: |
| Address: | |
| City: | State: Zip Code: |

| **MEDICAL INFORMATION**<br>Completed Gestational Age: | Birth Weight: kg☐/lb☐ |
|---|---|
| Most Recent Weight: kg☐/lb☐ | Date of Most Recent Weight: |
| Did the patient receive Synagis when hospitalized? ☐yes ☐no If yes, dates? | |
| Include the following medical records to support Synagis administration:<br>Hospital Discharge Summary ☐ Last Clinic Note ☐ | |

**SYNAGIS REFERRAL INFORMATION** (Check what applies)

Synagis (palivizumab) guidelines from the American Academy of Pediatrics (revised 11/2015)

☐Infants born at less than or equal to 28 6/7 weeks gestational age and who are younger than 1 year at the start of the RSV season, November 1. **List DX Code:**_____

☐Children with severe immune deficiency who may need prophylaxis, including another RSV season or more up to 48 months of age at the start of the RSV season, November 1. **List DX Code:**_____

☐Patients less than 24 months old who continue to require medical therapy from:

**Pediatric subspecialist only:**

**DX Code:**_____ Pulmonary-chronic lung disease (defined as <32wGA and requiring >21% O2 for at least the first 28 days after birth; <24 months at the start of Synagis season, medications not required)

**DX Code:**_____ Cardiology-congenital heart disease (24 months at the start of RSV season)

| **REFERRING PROVIDER INFORMATION**<br>Provider Name: | Specialty: |
|---|---|
| Office Phone #: | Office Fax #: |
| Office Address: | |

| **INSURANCE INFORMATION**<br>☐**Send a copy of insurance card (both sides)**<br>Subscriber Name: | DOB: |
|---|---|
| Health Plan: | Member ID: |
| Group #: | Authorization #: |

Signature:_____ Date:_____

**By providing the information requested and signing above, you agree that we may initiate treatment following consultation or perform medically necessary diagnostics, in association with this consultation. We look forward to collaborating with you on your patient's treatment plan.** NOTICE OF CONFIDENTIALITY: This is a confidential fax and is intended solely for the person indicated above. If you are not the intended person, you are hereby notified of the confidential nature of this fax and that you are not entitled to read, copy or otherwise disseminate any of the information contained herein.

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