Phone: (865) 862 - 4557 | www.heartlandinfusion.com | Fax: (865) 862 – 4556 | Alt. Fax: (865) 867 - 7081

Prolastin-C Order Form

Please fax completed form with patient demographic information, front and back of insurance card (s), recent lab results, and recent office visit notes supporting diagnosis to (865) 862-4556.

Referral Status: ☐ New referral ☐ Dose or frequency change ☐ Order Renewal

PATIENT INFORMATION

Name:

Home Phone: Cell Phone:

Email: Last four Social Security number

DOB: Height: Weight:

Allergies:

ICD-10 Diagnosis Code: Years with Disease:

TB Test (Circle One): Skin Quantiferon Chest Xray Result: Date:

LABORATORY ORDERS

☐ CBC w/ Diff ☐ each infusion ☐ Other ______

☐ CRP ☐ each infusion ☐ Other ______

☐ CMP ☐ each infusion ☐ Other ______

☐ ESR ☐ each infusion ☐ Other ______

☐ Hepatic Panel ☐ each infusion ☐ Other ______

☐ Renal Panel ☐ each infusion ☐ Other ______

☐ Quantiferon TB (annually) Due: ______

☐ Other

Therapy Orders

☐ Administer 60mg/kg (+/- 10%) Prolastin-C (alpha 1 proteinase inhibitor, human) IV once per week **OR**

Other (specify): ______

☐ Nursing per Heartland Nursing Procedures (incl reaction management)

☐ **Pre-Medications** ☐ No routine pre-medications required

☐ Tylenol (acetaminophen) ________ mg PO ☐ Zyrtec (cetirizine) 10 mg PO

☐ Solu-Medrol (methylprednisolone) ________mg IV ☐ Claritin (loratadine) 10 mg PO

☐ Benadryl (diphenhydramine) ________mg ☐ PO ☐ IV

☐ Other: ______

PHYSICIAN INFORMATION

Physician's Name:

License #: NPI#: DEA#:

Address:

City: State: Zip:

Office Contact: Email:

Office Phone: Office Fax:

Physician Signature: ______ Date: ______

Patient is being referred to: ☐ Knoxville ☐ Morristown ☐ Kingsport