Prolastin C Infusion Order

LivWell INFUSIONS

Fax 888 511-7654 Phone 888 864-7341

Patient Name: _____ **DOB:** _____

Patient Phone: _____ **SEX:** M ◯ F ◯

Please Attach All Insurance Information, front and back

MEDICAL INFORMATION

Diagnosis: ◯ E88.01 Alpha -1- proteinase inhibitor deficiency

◯ Other _____

Patients weight: _____

Lab Date: _____

Allergies: _____

ICD-10: _____

ALSO INCLUDE...

◯ Clinical/ Progress Notes

◯ Demographics Sheet

◯ Current Medications

◯ Labs

PROLASTIN-C ORDER

Prolastin- C Dose: ◯ 60 mg/ kg ◯ Other _____ mg/kg

Frequency: ◯ weekly ◯ Other_____

Patients weight: _____

Date of last Prolastin- C Infusion:_____

Additional Comments:

PHYSICIAN INFORMATION

Referring Physician: _____ **Phone:** _____

Practice Address: _____

Office Contact: _____ **Fax:** _____

NPI/ TIN: _____

Referring Physician's Signature_____ **Date:** _____