

PATIENT INFORMATION

Referral Status:

New Referral

Updated Order

Order Renewal

DOB:	Patient Name:	Patient Phone:	
Patient Address:		Patient Email:	
NKDA Allergies:	Weight (lbs/kg):	Height:	
ICD-10 code (required):	ICD-10 description:	Last Treatment Date:	Last 4 SSN:

PROVIDER INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:

NURSING

Infusion to be administered per BioHealth protocols.

LABORATORY ORDERS

- CBC at each dose every _____
- CMP at each dose every _____
- CRP at each dose every _____
- OTHER _____

PREMEDICATIONS

- acetaminophen (Tylenol) 500mg 650mg / 1000mg PO
- cetirizine (Zyrtec) 10mg PO
- loratadine (Claritin) 10mg PO
- diphenhydramine (Benadryl) 25mg 50mg PO IV
- methylprednisolone (Solu-Medrol) 40mg 125mg IV
- hydrocortisone (Solu-Cortef) 100mg IV
- Other: _____
- Dose: _____ Route: _____
- Frequency: _____

CRYSVITA THERAPY ADMINISTRATION

1 mg/kg body weight SQ every 4 weeks (Rounded to the nearest 10mg. Max of 90mg)

REQUIRED DOCUMENTATION

Patient Demographics

Insurance Card/Information

Progress Notes Supporting DX

Current Medication List and H&P

Elevated Serum Fibroblast 23>30 pg/ml (if available)

Serum Phosphorus

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions. **Order is valid for one year unless otherwise noted**

Provider Name (Print)

Provider Signature

Date

Have a Question? (786)460-6044
 Fax Referral Form To: (786)219-3917
 8684 SUNSET DRIVE MIAMI FL 33143