

SYNAGIS REFERRAL 2018-2019	Pediatric Diagnostic Center Synagis Coordinator Maria Perez Phone: 652-6604 Please provide insurance information. Gray mail with records (NICU records are necessary) FAX 652-3375 Or email maria.perez@ventura.org
If patient has CCS please complete CCS synagis referral form	
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): _____
 Birth Weight (Kg): _____
 Congenital Heart Disease? _____

Chronic Lung Disease? _____
 On Oxygen in Last 6 months? _____

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: