Children's Hospital
Greenville Health System

Synagis Enrollment Referral Form 2014-2015
Division of Pediatric Pulmonology
phone)864-454-5530 fax)864-241-9246

Date of Referral:_____

Name of child:_____ Former name in NICU:_____ DOB:_____Male/Female

Address:_____ Apt #:_____

City:_____ State:_____ Zip code:_____

Parent's Names:_____

Phones: h)_____ c)_____ w)_____

Primary insurance:_____ Pharmacy insurance:_____

Secondary insurance:_____ (please write out type of Medicaid if this is secondary)

******INCLUDE copies of both sides of the above cards with your referral******

Clinical Information

Gestational age:_____ weeks

Birth weight:_____KG

Current weight:_____ Date current weight obtained:_____

*******Include a copy of NICU discharge summary with referral *******

AAP/COID Recommended Synagis Eligibility Assessment (season officially begins 11/1/2014)
Infant MUST meet one of the criteria below to require therapy:

○ Born ≤29 weeks and under 12 months of age		○ Children under 24 months who are profoundly immunocompromised
○ Chronic lung disease/BPD <32 weeks with oxygen requirement for at least 28 days after birth and in the second year of life if still requiring oxygen, chronic corticosteroids or diuretic therapy	○ Congenital heart disease that is considered hemodynamically significant. Infant must be less than 1 year of age at season onset to qualify.	○ Children with neuromuscular disease that RSV infection could impair their ability to clear secretions may be dosed **in the first year of life ONLY**

Medications (please circle): inhaled/oral steroids bronchodilators oxygen lasix/diuretics sildenafil

Has the child received any Synagis for the 2014-2015 season? (No / Yes) If Yes, please give date(s):_____

Primary Care Provider:_____ Practice Name:_____

Address:_____

Back Line to your office:_____ Fax Number:_____

Name of Person Completing this Referral:_____

References: http://m.pediatrics.aappublications.org/content/early/2014/07/23/peds.2014-1665.full pdf