

## Patient information

Patient name \_\_\_\_\_

DOB \_\_\_\_\_

Mobile number \_\_\_\_\_

Weight \_\_\_\_\_  kgs  lbs

Diagnosis  Emphysema due to severe deficiency of alpha - p1 (alpha - antiitrypsin deficiency), ICD 10: e88.01

Other \_\_\_\_\_

Allergies  NKDA  \_\_\_\_\_

## Medication instructions

Pre-medications  N/A

Provider prescribed: \_\_\_\_\_

Medication order

Dose

60 mg/kg body weight intravenously

Other \_\_\_\_\_

Frequency

Iv once per week

Other \_\_\_\_\_

Medication route

N/A

Other \_\_\_\_\_

Lab order

(Include frequency)

Please list any labs to be drawn by the infusion clinic:

N/A

\_\_\_\_\_

Prerequisites

Please include the following with your fax submission: Labs and tests supporting diagnosis | Office / progress notes | Demographics

Please send to

Columbia, MD

Silver Spring, MD

Bowie, MD

Frederick, MD

## Referring provider information

Referring provider name \_\_\_\_\_

NPI \_\_\_\_\_

Practice name \_\_\_\_\_

Point of contact

Name \_\_\_\_\_

Email \_\_\_\_\_

Phone \_\_\_\_\_

Provider signature

\_\_\_\_\_

Date \_\_\_\_\_