vitalcare® of the FOUR STATES

ALPHA-1 REFERRAL FORM

Vital Care of the Four States, 109 E Hickory St., Neosho, MO 64850
OFFICE 417-451-7900 / FAX 417-451-7915

DEMOGRAPHICS

Patient Name: _____

Address: _____

City: _____ State: ____ Zip:_____

DOB: ____/____/____ ☐ Male ☐ Female

Phone: _____

SSN: _____ Ht: _____ Wt: _____

PRESCRIBING PHYSICIAN

Name: _____

Address: _____

City: _____State: _____ Zip: _____

Phone: _____ Fax: _____

License#: _____

DEA#: _____NPI: _____

ALLERGIES / REACTIONS

_____

PHYSICIAN ORDERS

☑ **ARALAST [**Alpha - Proteinasse Inihibitor (Human)**]** **QUANTITY:** 4 weeks **REFILLS:** _____

60 mg/kg x _____ kg (patient's weight)= TOTAL DOSE _____ MG IV once weekly

****Acceptable allotment +/- 10% based on vial lot/batch**

☐ **OTHER** **REFILLS:** _____

_____

☑ **Anaphylaxis Kit per Pharmacy protocol**

TO BE ADMINISTERED BY THE HEALTH CARE PROVIDER **PRN** FOR PATIENTS RECEIVING IV MEDS IN THE HOME

Epinephrine Auto Injector 0.3mg/0.3ml IM – Repeat one time in 20 minutes if needed

IV / ACCESS / MAINTENANCE:

☑ PORT - Flush before & after medication with 10ml NS. Lock with Heparin 500units/5ml

☐ PICC - Flush before & after medication with 10ml NS. Lock with Heparin 50units/5ml

☐ PERIPHERAL - Flush before & after medication with 10ml NS. Discontiue IV after infusion

DIAGNOSIS:

☑ E88.01 Alpha-1 antitrypsin deficiency

Signature: _____

Date: _____