



Prolastin C Infusion Order

Fax 281-715-5302 Phone 281-265-0100

Patient Name: _____
Patient Phone: _____

DOB: _____
SEX: M F

Please Attach All Insurance Information, front and back

MEDICAL INFORMATION

Diagnosis: E88.01 Alpha -1- proteinase inhibitor deficiency
Other _____

ICD-10: _____

Patients weight: _____
Lab Date: _____
Allergies: _____

ALSO INCLUDE...

Clinical/ Progress Notes
Demographics Sheet
Current Medications
Labs

PROLASTIN-C ORDER

Prolastin- C Dose: 60 mg/ kg Other _____ mg/kg
Frequency: weekly Other _____

Patients weight: _____

Date of last Prolastin- C Infusion: _____

Additional Comments:

PHYSICIAN INFORMATION

Referring Physician: _____ **Phone:** _____

Practice Address: _____

Office Contact: _____ **Fax:** _____

NPI/ TIN: _____

Referring Physician's Signature _____ **Date:** _____