Prolastin-C Infusion Order

INFUSION FOR HEALTH

Ph: 805-719-3700 | Fax: 805-852-2636

Date: ____ / ____ / ____ Treatment Location: _____

***Please fax a copy of the following patient information:**

- ☐ Demographics
- ☐ Insurance Information
- ☐ Current Lab Results
- ☐ H & P Relevant to Diagnosis
- ☐ Current Medications
- ☐ Alpha, Antitrypsin Lab Result

PATIENT INFORMATION

Patient Name: _____

DOB: ____ / ____ / ____

Allergies: _____

Weight: _____ lbs / kg Height: _____

Diagnosis: _____

ICD-10: _____

PROVIDER INFORMATION

Printed Provider's Name: _____

Signature: _____

NPI: _____ Date: ____ / ____ / ____

Phone: (____) ____ - ____ Fax: (____) ____ - ____

Office Address: _____

Contact Person: _____

PROLASTIN-C (Alpha$_1$-PI) DOSAGE

60 mg/kg (+/-10%)= _____ mg once weekly

Start date of infusion: _____