Sarah Bush Lincoln

PATIENT INFORMATION

Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)

Preferred Location* ☐ Mattoon ☐ Effingham

*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.

Diagnosis and ICD 10 CODE

☐ Type I Gaucher Disease ICD 10 Code: E75.22

REQUIRED DOCUMENTATION

☐ This signed order form by the provider
☐ Patient demographics AND insurance information
☐ Beta-glucosidase leukocyte (BGL) Enzyme Test Results
☐ Clinical/Progress notes
☐ Labs and Tests supporting primary diagnosis
☐ Pregnancy Test (if applicable)

Please indicate if your patient's disease has caused any of the following, check all that apply:

☐ Anemia ☐ Moderate to Severe Hepatosplenomegaly ☐ Skeletal Disease ☐ Thrombocytopenia (Plt ≤ 120,000)
☐ Symptomatic Disease (bone pain, fatigue, dyspnea, angina, abdominal distention, or diminished QOL)

MEDICATION ORDERS

**Patient weight required for weight-based orders.

Dosing Wt for Calculations Ht: Wt (in kg): BMI:

Dosing	☐ Cerezyme 60 units/kg IV every 2 weeks** ☐ Cerezyme _____ units/kg IV _____ ** (Dosing ranges from 2.5 units/kg given 3 times per week to 60 units/kg given every 2 weeks)

Refills: ☐ **X 6 months** ☐ **X 1 year** ☐ _____ **doses (all doses including initial loading)**

ADDITIONAL ORDERS

PRESCRIBER INFORMATION

Prescriber name :		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date: Time:

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Contact us with questions at:
Fax Completed Form and all documentation to:

☐ MATTOON
1000 Health Center Dr. Ph. 217-258-4150
Suite 204 Fax 217-348-2579
Mattoon, IL 61938

☐ EFFINGHAM
901 Medical Park Dr. Ph. 217-342-7500
Suite 201 Fax 217-342-7499
Effingham, IL 62401

INFUSION ORDERS - CEREZYME (IMIGLUCERASE)

Clinics Scan to: Physician Orders