

Chicago Illinois
4711 Golf Road
Suite 900
Skokie, IL 60076



(C1 esterase inhibitor)

CINRYZE infusion orders

Date: _____

Patient Name _____ DOB _____

Phone _____ M F

REFERRAL STATUS

Allergies: _____

- New Referral
- Medication/Order Change
- Discontinuation Order
- Referral Renewal
- Benefits Verification Only

DIAGNOSIS D84.1 - D84.1 - Defects in the complement system (C1 esterase inhibitor [C1-INH] deficiency)

_____ (other)

PER-MEDICATION

- Tylenol 1000mg PO
- Solu-Medrol 125mg IVP
- Diphenhydramine 25mg PO
- Solu-Cortef 100mg IVP
- Cetirizine 10mg PO
- Diphenhydramine 25mg IVP
- _____ (other)
- _____ (other)

CINRYZE ORDERS

<p>DOSAGE</p> <p><input checked="" type="radio"/> 1,000u IV every 3-4 days</p> <p><input type="radio"/> Other</p> <p>TOTAL DOSES: 1 yr _____ Other _____</p>	<p>PATIENT WEIGHT</p> <p>_____ lbs.</p> <p>_____ kg</p> <p>Refill _____</p>
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NOTES

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____