

TN
100 Covey Drive
Suite 307
Franklin, TN 37067

(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

DOSAGE

1,000u IV every 3-4 days

Other

PATIENT WEIGHT

_____ lbs.

_____ kg

TOTAL DOSES: 1 yr _____ Other _____ Refill _____

NOTES

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____