

Borough Park
1428 36th Street
Suite 107
Brooklyn, NY 11218

Crown Heights
555 Lefferts Avenue
Brooklyn, NY 11225

Manhattan
57W 57Street
Suite 601
New York, NY 10019

Manhasset
333 East Shore Road
Suite 201
Manhasset, NY 11030

Rockville Centre
165 North Village Avenue
Suite 133
Rockville Center, NY 11570

Elmsford/Tarrytown
555 Taxter Road
3rd Floor
Elmsford, NY 10523



I N F U S I O N
Office: 212-803-3339 Fax: 646-768-8600



Manhattan
225 E 70th Street
Suite 1E
New York, NY 10021

Queens
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375

Manhattan
225 East 70th Street
New York, NY 10021

Holbrook/Ronkonkoma
233 Union Ave
Suite 207
Holbrook, NY 11741

Scarsdale
495 Central Park Avenue
Suite 205
Scarsdale, NY 10583

5 Towns
141 Washington Avenue
Cedarhurst, NY 11559

Long Beach
917 Beech Street
Long Beach, NY 11561

Riverhead
1228 E Main Street
Suite A
Riverhead, NY 11901

PROLASTIN®

Date: _____

PATIENT INFORMATION

Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
Allergies:	Date of Referral:	

PHYSICIAN INFORMATION

Physician Name*:	Practice Name:
Address:	Office Contact*:
Phone: _____ Fax: _____	Email (for updates): _____

REFERRAL STATUS

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

PROLASTIN*:

(SELECT ONE OF THE FOLLOWING)

___ Dosing: 60 mg/kg body weight intravenously once per week (+/- 10%)

Physician Signature _____ Date (Order is Valid for One Year) _____

REQUIRED DIAGNOSIS:

___ Alpha1 Antitrypsin Deficiency
Emphysema
___ Other _____

REQUIRED DOCUMENTATION CHECKLIST:

___ Patient Demographics
___ Insurance Card/Information
___ Clinical/Progress Notes supporting DX
___ Current Medication List and H&P

Last Infusion/Injection Date: _____

STANDING LAB ORDERS Labs to be drawn by Infusion Center _____ Frequency _____

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____