

Intravene - Glassia Infusion Orders (rev 10/2015)

Please fax this form along with a copy of insurance cards to:

Fax (434) 455-5531 or Call (434) 947-3900 ext. 2172

PATIENT INFORMATION

Name _____

Address _____

City _____

State _____ Zip code _____

Home Phone # _____

Work Phone # _____

DOB _____ SSN _____ Sex _____

Height _____ Weight _____

Allergies _____

Primary Insurance _____

Secondary Insurance _____

DIAGNOSIS: (ICD-10 required)

- _____
- _____
- _____ ↑

REFERRING PHYSICIAN INFORMATION

Physician Name _____

Physician Address _____

Physician Phone _____

Physician Fax _____

NPI# _____ DEA # _____

State License# _____

**** Please fax copy of insurance cards**
Current office visit notes if available
and this form to (434)- 455-5531**

Serum AAT Level: _____ mg/dL or _____ uM Date: _____

PFT: FEV₁ % Pred _____ O₂ Therapy: _____ l/min Date: _____

CXR/CT Results: _____ Date _____

Phenotype: _____

Current or former smoker? Yes or No (circle one)

If former smoker, date stopped: _____

STANDARD ORDERS

- Prescription: Glassia (Alpha,-Proteinase Inhibitor-Human) **HCPC Code-J0257

Ordered Dose: _____ mg

- Frequency: Weekly _____

- Other Frequency: _____

Refills: (Months): _____

Patient weight _____ lbs _____ kg (2.2 lb=1 kg)

Signature, prescribing MD _____ Date _____

Anaphylactic meds available at the chairside:

Epinephrine 1:1000 1mg ampule. Administer 0.5ml (0.5mg) by SQ injection upon order of MD

Hydrocortisone 100mg vial. Administer 100mg IV push upon order of MD

Diphenhydramine 50mg vial. Administer 50 mg IV push upon order of MD

VITAL SIGNS MONITORING PER INTRAVENE PROTOCOL