Children's Physician Group—Pulmonology

Children's℠ Healthcare of Atlanta

2024-2025 Synagis Enrollment Form

****PLEASE include a copy of insurance/Medicaid card and NICU discharge summary.****

_____
Today's date

_____
Referral form completed by

_____
Direct contact phone number

_____
Pediatrician name

_____
Practice name

_____
Practice zip code

_____
Pediatrician phone number

_____
Pediatrician fax number

_____
Referring physician name
(if different than pediatrician)

Patient's name: _____ Gender: □ M □ F
Parent/guardian names: _____
Address: _____
Phone (H): _____ (W): _____ (C): _____
Primary insurance name/ID#: _____
Policy holder's name: _____ DOB: _____
Secondary insurance name/ID#: _____

PATIENT INFORMATION

Date of birth: _____ Gestational age: _____ weeks _____ days
Birth hospital: _____ NICU discharge date: _____
Birth weight: _____ lb/kg Current weight: _____ lb/kg
Current height: _____ in/cm Date weight and height were taken: _____
Has this child received Synagis this season? □ Yes □ No Date: _____
Has this child received Beyfortus this season? □ Yes □ No Date: _____

AAP GUIDELINE ASSESSEMENT (select appropriate qualifying description)

□ **Prematurity**: Born before 29 weeks gestation and birthdate after 10/1/2023.

□ **CLD First Year of Life**: Born before 32 weeks gestation and has chronic lung disease (CLD) with a requirement for supplemental oxygen for at least the first 28 days of life and birthdate after 10/1/2023.

□ **CLD Second Year of Life**: Born before 32 weeks gestation and has CLD with a requirement for supplemental oxygen for at least the first 28 days of life and birthdate after 10/1/2022 and has required treatment with chronic corticosteroids, diuretics or oxygen after 4/1/2024.
Medications: _____

□ **CHD**: Hemodynamically significant congenital heart disease (CHD) requiring congestive heart failure medical management and birthdate after 10/1/2023.
- □ Cyanotic or acyanotic heart disease
- □ Moderate to severe pulmonary hypertension

□ **Neuromuscular/airway**: Neuromuscular disease or congenital anomaly that impairs ability to clear airway secretions and birthdate after 10/1/2023.
Diagnosis: _____ Diagnosis code: _____

□ **Cystic fibrosis**: CF with clinical evidence of CLD and/or nutritional compromise for which they are receiving treatment and born after 10/1/2023.

REFERRAL INSTRUCTIONS

Select your preferred location and fax this form to 404-785-0596. Contact Jessica Van Emburgh, Program Manager, at 404-785-0588 ext. 11721 with questions.

□ **Mount Vernon Highway** □ **Center for Advanced Pediatrics**