Pediatric Growth Hormone Referral Form

BIOMED Pharmaceuticals **Phone: (817) 923-4495** **Toll Free: (866) 923-4495** **Intake Fax: (866) 923-4492**

Corporate Office	Desoto	Houston	Tyler	San Antonio
1512 8th Ave. Suite 100	2727 Bolton Boone Dr. Ste 110	1919 N. Loop West, Ste 180	837 S. Fleishel	211 North San Saba, Suite 205

Name: _____ Date of Birth:_____ Allergies:_____

Address:_____ City:_____St._____ Zip_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____ Male___ Female___

Emergency Contact Name_____ Relationship_____

Emergency Contact Phone #_____ Primary Language_____

Primary Insurance: _____

Phone #:_____

Subscriber: _____ DOB: _____

ID#: _____ Policy/Group #: _____

Employer:_____

Secondary Insurance: _____

Phone #:_____

Subscriber: _____ DOB: _____

ID#: _____ Policy/Group #: _____

Employer_____

Prescription Drug Card: Name _____ Group# _____ ID# _____

Diagnosis:

___ Isolated Growth Hormone Deficiency (253.3)
___ Panhypopitutiarism (253.2)
___ Pituitary Neoplasm (237.0)
___ Other (specify ICD-9) _____
___ Iatrogenic Hypopituitarism—hypophysectomy induced, postablative, or radiotherapy-induced (253.7)
___ Other Disorders of pituitary (253.8)

Medical Assessment:

Weight _____(lbs) _____(kg) Height _____cm _____% Mother Height _____cm Father Height _____cm

GH Stimulation Test Date _____ Growth Velocity _____cm/yr Skeletal X-Ray Date _____ Bone Age _____y _____m

Gestational Age _____ Chronological Age _____y _____m If SGA: Birth Weight_____ Birth Length _____

Agent 1 _____ Peak_____ Test _____ Result _____

Agent 2 _____ Peak_____ Test _____ Result _____

Prescription:

Genotropin MQ_____ 0.2mg____ 0.4mg____ 0.6mg____ 0.8mg____ 1mg____ 1.2mg____ 1.4mg____ 1.6mg____ 1.8mg____ 2mg____
Genotropin Pen_____ 5.8mg____ 13.8mg____
Nutropin AQ Pen_____ 10 mg____
Nutropin AQ vial_____ 10 mg____
Nutropin_____ 5mg____ 10mg____
Protropin_____ 5mg____ 10mg____
Norditropin_____ 4mg____ 8mg____
Humatrope_____ 5mg____ 6mg____ 12mg____ 24mg____
Saizen_____ 5mg____
Omnitrope_____ 1.3 mg / ml-single use vials_____ 5.0 mg / ml-Pen_____

___ Starter Kit
___ Request teach in MD office
___ Request teach in home AAIC Clinic
___ Pen needles 29g____ 30g____ 31g____
___ BD Ultra Fine
___ Other_____

Dose to be given subcutaneously:

Dose_____ Frequency_____ Days Supply_____ Refills_____(months) Start Date_____

Prescription Special Instructions:_____ Ship By_____

Physician Certification: _____TPI # _____ UPIN# _____Tax ID# _____NPI#

Signature:_____Date_____

Print Name:_____ DEA #_____

Address:_____ City_____ State_____ Zip_____

Phone:_____ Fax:_____ **Thank you for your referral.**

BIOMED **Please send front and back copies of all insurance cards with referral.**

1-16-08