ALERE REFERRAL

Physician NPI: _____

Practice Zip Code: _____

Physician License #: _____

TO: REFERRAL TEAM – S. FLORIDA **Physician Name:** _____

FAX: 866-252-4293 **Practice:** Fax: _____ Phone: _____

PHONE: 800-999-2106 **Office Contact:** _____

DATE: _____ **Patient Location** *(at time of referral)*: ❑ Home ❑ Hospital ❑ Other: _____

PATIENT INFO: Name: _____ DOB: _____ State of Residence: _____

Phone (H): _____ Phone (C): _____

TO GENERATE ALERE Physician Plan of Treatment: (Check One)

❑ **UTILIZE ALERE PROTOCOL / PREFERENCES ON FILE** **OR** ❑ **CALL FOR PATIENT-SPECIFIC ORDERS AT:** _____

SERVICE REQUESTED: (CHECK ALL THAT APPLY)

NAUSEA & VOMITING MANAGEMENT	❑ Ondansetron (Zofran®) ❑ Continuous SQ **OR** ❑ Continuous PICC ❑ Metoclopramide (Reglan®) ❑ Continuous SQ **OR** ❑ Continuous PICC
HYDRATION MANAGEMENT	❑ Peripheral IV ❑ PICC Line Fluid type: _____ Rate: _____ Liters/day: _____
NURSING SURVEILLANCE	Preterm Labor Management: ❑ Singleton Pregnancy ❑ Multiple Gestation ❑ Preterm Premature Rupture of Membranes Program: ❑ NST _____ times per week
COAGULATION DISORDERS	❑ Heparin Subcutaneous Infusion Pump
HYPERTENSION MANAGEMENT	❑ Hypertension Program ❑ Pre-eclampsia Program
DIABETES MANAGEMENT	❑ Non Insulin ❑ Insulin Injections ❑ Insulin Pump
PRETERM BIRTH PREVENTION	❑ Makena™ Administration Nursing and Care Management Service *(MD or patient to procure medication)* ❑ 17P Administration Nursing and Care Management Service *(Includes pharmacy compounded 17 alpha-hydroxyprogesterone caproate)*

WHEN 17P IS SELECTED ABOVE, MAKE APPROPRIATE SELECTION IN <u>EACH</u> COLUMN BELOW OR PROVIDE DETAILS IN "OTHER" SECTION

❑ Singleton pregnancy 16-0/7 to 20-6/7 wks gestation and history of singleton spontaneous preterm birth

Date of Delivery: _____

GA at Delivery: _____

❑ Other risk factors for spontaneous preterm birth: _____

❑ Sensitivity to preservatives

❑ Risks associated with benzyl alcohol

❑ Other *(describe)*: _____

❑ Other: _____

ATTACH THE FOLLOWING DOCUMENTS WITH YOUR REFERRAL SUBMISSION:

❑ FACE Sheet/Demographic Sheet ❑ Prenatal Records / Progress Notes / MFM Consultation Report

❑ Front and Back of Insurance Card

Has request for service been discussed with patient? ❑ Yes ❑ No

Does Alere have permission to contact the patient? ❑ Yes ❑ No

ADDITIONAL COMMENTS:

Alere will respond via fax to acknowledge receipt, request any missing documentation, and provide a Physician Plan of Treatment (PPOT) form for signature.

Thank You For Your Referral !