

# SYSTEMIC LUNG DISEASES REFERRAL FORM

## PATIENT INFORMATION (please attach insurance card)

Name: \_\_\_\_\_  M  F DoB: \_\_\_\_\_

Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_ Allergies: \_\_\_\_\_

## CLINICAL INFORMATION (please attach clinical notes and labs)

**Diagnosis with ICD-10 code**

**J84.9** interstitial lung disease (ILD)  **D86.9** sarcoidosis, unspecified  **J84.112** idiopathic pulmonary fibrosis (IPF)

**M34.81** systemic sclerosis with lung involvement (SSc-ILD)  **M05.10** rheumatoid lung disease (RA-ILD)  **M34** systemic sclerosis/scleroderma

**Other:** \_\_\_\_\_

ht: \_\_\_\_\_ in/cm wt: \_\_\_\_\_ lb/kg

### Labs & Procedures (please attach most recent results):

CMP  PFTs  HRCT, date: \_\_\_\_\_

Current medication(s) with date(s) started: \_\_\_\_\_

Prior medication(s) with date(s) of use: \_\_\_\_\_

## PRESCRIPTION

**DAW** (deliver to  patient  office)

Medication	Dose/Strength	Directions/Sig	Quantity	Refills
<input type="checkbox"/> bosentan	<b>Tabs:</b> <input type="checkbox"/> 32mg <input type="checkbox"/> 62.5mg <input type="checkbox"/> 125mg			
<input type="checkbox"/> cyclosporine, modified (Gengraf, Neoral)	<b>Caps:</b> <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg <input type="checkbox"/> 100mg <b>Soln:</b> <input type="checkbox"/> 100mg/mL			
<input type="checkbox"/> cyclosporine, non-modified (SandIMMUNE)	<b>Caps:</b> <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg <input type="checkbox"/> 100mg <b>Soln:</b> <input type="checkbox"/> 100mg/mL			
<input type="checkbox"/> Jascayd	<b>Tabs:</b> <input type="checkbox"/> 9mg <input type="checkbox"/> 18mg			
<input type="checkbox"/> mycophenolate mofetil (Cellcept)	<b>Caps:</b> <input type="checkbox"/> 250mg <b>Tabs:</b> <input type="checkbox"/> 500mg			
<input type="checkbox"/> nintedanib (Ofev)	<b>Caps:</b> <input type="checkbox"/> 100mg <input type="checkbox"/> 150mg			
<input type="checkbox"/> pirfenidone (Esbriet)	<b>Caps:</b> <input type="checkbox"/> 267mg <b>Tabs:</b> <input type="checkbox"/> 267mg <input type="checkbox"/> 534mg <input type="checkbox"/> 801mg			
<input type="checkbox"/> Pulmozyme	2.5mg/2.5mL inh soln	2.5mg inh _____ times per day		
<input type="checkbox"/> tobramycin	<input type="checkbox"/> 300mg/5mL inh soln <input type="checkbox"/> 300mg/4mL inh soln <input type="checkbox"/> Bethkis 300mg/4mL inh soln PF <input type="checkbox"/> Tobi 300mg/5mL inh soln PF <input type="checkbox"/> 300mg/5mL inh soln PF <input type="checkbox"/> 300mg/4mL inh soln PF	300mg inhaled via nebulizer every 12 hours for 28 days. Stop for 28 days then repeat cycle		
<b>Other:</b>				

## PRESCRIBER INFORMATION

Prescriber: \_\_\_\_\_ Supervising Physician: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Contact Method:  Phone  Fax  Email:

Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Fax: \_\_\_\_\_

Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ NPI: \_\_\_\_\_