SYNAGIS REORDER FORM

317 Nassau Blvd South
Garden City NY 11530
Phone: 516-292-7788
Fax: 516-292-5103
Specialty@AmericarePS.com

THIS INFORMATION IS NECESSARY FOR SUBSEQUENT DOSES.

Patient's Name:____DOB:_____________________

Date of Injection:____

Patient's Weight at Time of Injection:____

Amount Injected:____ Circle unit: MG ML

MD/Nurse Contact Number:____

If Synagis is no longer needed, reason for discharge:____________________________________

RETURN THIS FORM TO US AS SOON AS POSSIBLE

by mail, email, or fax, or you can call it in verbally to us.

Please Note: If you require a dose after regular season end date (usually March 31st), you must call our office. It will not be sent automatically.