CURBSIDE INFUSION SERVICES

Fax To: 281-406-1047
Email To: referrals@curbsideinfusion.com
Office: 281-406-1046

CINRYZE (C1 esterase inhibitor) infusion orders

Patient Name _____ DOB _____

Phone _____ M ○ F ○

DIAGNOSIS *Please provide ICD-10 code*

☐ **D84.1** Defects in the complement system (C1 esterase inhibitor [C1-INH] deficiency)

☐ _____ _____
(other)

PRE-MEDICATION

☐ Tylenol 1000mg PO
☐ Diphenhydramine 25mg PO
☐ Cetirizine 10mg PO
☐ Quzyttir 10mg IVSP over 1-2 min
☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
☐ _____
(other)

CINRYZE ORDERS

DOSAGE

◉ 1,000u IV every 3-4 days

PATIENT WEIGHT

_____ lbs.

_____ kg

NOTES

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____

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