Amerigroup RealSolutions in healthcare

Growth Hormone Clinical Management Initial Request Adults

Member	Member Name:	Member Phone #: ( ) -	Member ID #:	Date of Birth:
	Street Address:			Apt. #:
	City:	State:		ZIP:
Physician	Name:	Facility Name:		
	Facility Phone #: ( ) -	Fax #: ( ) -	Pager #: ( ) -	
	Street Address:			Apt #:
	City:	State:		ZIP:

BASELINE TESTS	RESULT	DATE
Chronological Age	___Years ___Months	
Height (actual and SD or percentile)	___Feet ___Inches or %	
Weight (actual and SD or percentile)	___Pounds ___%	
GH Assay (method)	(indicate method) _____	
Serum Growth Factors	___1GF-1 ___1GFBP-3	
GH Provocation Test x2	(Indicate stimuli and peak GH values) ___#1 ___#2	
Thyroid Function Tests	Thyroxine: ___ TSH: ___	
Lipid Levels	Trigly. Chol.	
HbA1c	___ / ___	
Bone Density (optional)		

Clinical Diagnosis of Indications for GH Therapy:

Treatment Plan and Anticipated Duration:

Print Name: _____

Signature:_____

Date: _____