Intravenous Immune Globulin Patient Referral Form

Patient Demographics Information

Patient Name	SSN#	DOB

Patient Address

Primary Phone	Cellular Phone	Work Phone

Emergency Contact Name, Relationship	Emergency Contact Phone Number

Additional Documentation Needed

- ❁ Copy of insurance cards
- ❁ Patient face sheet w/demographics
- ❁ History and Physical
- ❁ Labs to include IgA level (within 1 year)
- ❁ CBC w/dif, BMP, & CMP
- ❁ Recent vitals including blood pressure
- ❁ For immune deficiency, detailed infection history, baseline IgG levels, vaccine responses
- ❁ Blood type

Patient Insurance Information

Insurance Plan #1		Insurance Plan #2	
Subscriber Name	DOB	Subscriber Name	DOB
Policy Number	Group ID	Policy Number	Group ID

Patient Clinical Information

Gender	Height (inches)	Weight (lbs)	Allergies (food/drug)
☐M ☐F			

Statement of Medical Necessity / Primary Diagnosis

Line Access Information:

Neurology Referrals		Immunology Referrals	
ICD10	Description of diagnosis	ICD10	Description of diagnosis

Medication Information / Prescription and Orders

Medication	Dose	Directions	Quantity / Refills
☐ Preferred Product ☐ No Preference	**Loading:** _____ gms OR _____ gm/kg given over _____ days **Main:** _____ gms OR _____ gm/kg *(rounded to the nearest vial size)* IV every_____week(s)	Infuse IV per manufacturer guidelines **OR** over _____ hours. Titration rate according to pharmacy protocol.	Dispense: 1 months supply, refill x12mos unless otherwise noted ☐ Other

First Dose?	If NO, List Product	Date of last Infusion	Next Dose Due
☐Y ☐N			

Line Access

RN to start peripheral IV or use existing CVAD. RN to administer catheter flushing and medications as directed.

☐ Sodium Chloride 0.9% 10 mL Flush: Flush with 2-10 mL sodium choride 0.9% IV before and after medication administration or every 24 hours while IV access in place.

☐ Sodium Chloride 0.9% 10 mL STERILE Flush: Flush with 5-10 mL STERILE sodium chloride 0.9% IV as needed for port access.

☐ Heparin Lock 100U/mL 5 mL Flush: Lock with 5 mL heparin 100U/mL after each use or daily while port accessed.

Quantity / Refills

Quantity #QS + PRN refills unless otherwise noted

☐ Other

Premedications

☐ **Give premedication 30 minutes prior to infusion** *(generics will be dispensed)*

Diphenhydramine:	☐ 25-50 mg PO
Antihistamine:	☐ Fexofenadine 180 mg PO
Methylprednisolone:	☐ 40 mg slow IV push over 5 minutes **OR** 125 mg slow IV push over 5 minutes
Acetaminophen:	☐ 325-650 mg PO **OR** ☐ _____ mg PO

☐ EMLA topical cream (Lidocaine 2.5% and Prilocaine 2.5%): apply to IV site prior to access PRN for pain upon needle insertion.

☐ Sodium Chloride 0.9% 500 mL - 1000 mL IV over 1-2 hours as tolerated daily PRN for hydration and/or headache.

☑ RN to instruct patient to hydrate pre/post infusion.

☐ RN to instruct patient to take Diphenhydramine 25-50 mg PO (max dose 400 mg/daily) and Acetaminophen 325-650 mg PO (max dose 3000 mg/daily) every 4-6 hours for 24-48 hours as needed to prevent/treat post infusion headache. Notify Physician if headache persists/worsens.

☐ Other (Physician to specify):

Adverse Reaction Orders

In the event of an infusion reaction (ie: fever, chills, backache, headache, rigors) the following orders will be followed and physician will be notified.

❁ Mild reaction: Diphenhydramine 50 mg PO x1 dose and slow infusion.
If needed, give an additional dose of Diphenhydramine 50 mg PO x1 dose (Max 2 doses)

❁ Moderate reaction: Diphenhydramine 50 mg po x1 dose and stop infusion;
Sodium Chlroide 0.9% 250mL , infuse at a rate up to 250 mL/hr as needed.

❁ Severe reaction (w/breathing problems): CALL 911, Diphenhydramine 50mg IM x1 dose and administer Epinephrine IM 0.3 mg or 0.15mg (as det by patient weight).

Prescriber Information

Physician Name	Office Contact

Practice Address	Practice Phone

NPI#	License #	DEA#

Physician Signature Required - Substitution Permitted	Date	Physician Signature Required - Dispense as Written	Date