Pediatric 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% 5 mL Flush: Flush with 3 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 **10U/mL** 5 mL Flush: Lock with 3-5 mL heparin **10U/mL** after each use or daily while port accessed.

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

Dispense:

Quantity #QS + PRN refills unless otherwise noted

☐ Other

Premedications

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

Diphenhydramine: ☐ _____ mg po (Diphenhydramine 12.5 mg/5mL Liquid - #1 bottle)

Acetaminophen: ☐ _____ mg po (Acetaminophen 160 mg/5 mL oral susp - #1 bottle)

Other: (Physician to specify)

☐ EMLA cream (Lidocaine 2.5% and Prilocaine 2.5%) topically: apply to IV site prior to access PRN for pain upon needle insertion. #1 tube

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

☐ 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 to moderate reaction: Diphenhydramine 1 mg/kg (≤ 25 kg) or 25 mg (> 25 kg) PO x1 dose and stop infusion until symptoms resolve. Maximum 50 mg/dose. May repeat every 6 to 8 hours. Dispense Diphenhydramine 12.5 mg/5 mL liquid.

❁ Severe reaction (w/breathing problems): CALL 911; administer Epinephrine IM 0.1 mg, 0.15 mg, or 0.3 mg **(as determined 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