# Pediatric Subcutaneous 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 ☐M ☐F | Height (inches) | Weight (lbs.) | Allergies (food/drug) |
|---|---|---|---|
| | | | |

## Statement of Medical Necessity / Primary Diagnosis

| Neurology Referrals | Immunology Referrals |
|---|---|
| ICD10 Description of diagnosis | ICD10 Description of diagnosis |

## Medication Information / Prescription and Orders

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

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

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

☑ Instruct patient or caregiver to hydrate pre/post infusion.

☐ Other (Physician to specify):

### Quantity / Refills

Dispense:

Quantity #QS + PRN refills unless otherwise noted

☐ Other

### 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 pause infusion until symptoms resolve. May repeat every 6 to 8 hours. Maximum 50 mg/dose. Dispense Diphenhydramine 12.5 mg/5 mL liquid.

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

## 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 |
|---|---|---|---|
| | | | |