

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

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	Loading: _____ gms OR _____ gm/kg given over _____ days	Infuse IV per manufacturer guidelines OR over _____ hours.	Dispense: 1 months supply, refill x12mos unless otherwise noted
☐ No Preference	Main: _____ gms OR _____ gm/kg (rounded to the nearest vial size) IV every _____ week(s)	Titration rate according to pharmacy protocol.	☐ Other
First Dose?	If NO, List Product	Date of last Infusion	Next Dose Due
☐ Y ☐ N			

Line Access	Line Type: ☐ PIV ☐ Port/CVAD	Dispense:
RN to start peripheral IV or use existing CVAD. RN to administer catheter flushing and medications per orders below.		Quantity #QS + PRN refills unless otherwise noted
☐ Sodium Chloride 0.9% 5 mL Flush: Flush with 3 mL sodium chloride 0.9% IV before and after medication administration or every 24 hours while IV access in place.		☐ Other
☐ 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.		
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