Intravenous Immune Globulin (IV) Referral Form

Patient name: _____ Address: _____

City:_____ State: _____ Zip: _____ Home phone: _____ Cellular phone:_____

DOB: _____ Male ☐ Female ☐

Work phone: _____ Emergency contact: _____ Phone:_____

ICD-10 codes: _____/_____/_____/_____/_____

Has the patient previously received Ig? Yes ☐ No ☐ Which product? _____ When? _____

Is patient diabetic? Yes ☐ No ☐ Is patient new to Ig? ☐

Is patient currently part of a clinical trial? Yes ☐ No ☐

Known allergies? Yes ☐ No ☐ If yes, please list: _____

Weight: _____ kg ☐ lbs ☐

***To expedite referral processing, please include copy of: 1.) insurance card, front and back 2.) H&P 3.) labs 4.) diagnostic test results**

Orders:

Initial: _____ gm/kg/day IV for _____ days every _____ week(s) administer via peripheral IV ☐ or CVAD ☐

Ongoing: _____ gm/kg/day IV for _____ days every _____ week(s) administer via peripheral IV ☐ or CVAD ☐

***Include VAD report if applicable.**

Other: _____

Product choice: _____

Refill x _____months, dispense 1 month supply. Infuse per Mfr. guidelines unless otherwise ordered.

***An ANAPHYLAXIS KIT will be provided.**

Pre-medications to be given 30 minutes prior to each Ig dose:

Acetaminophen 650 mg PO ☐ Diphenhydramine 25 mg ☐ IV ☐ PO ☐ None ☐ Other: _____

***Nursing or arrange patient/caregiver education as needed.**

Labs:

☐ IgG trough in 3 months, then every 6 months; **or**

☐ IgG trough every 6 months; **or**

☐ Other: _____

Prescriber: _____ Phone number: _____ Fax number: _____

DEA#:_____ NPI#: _____ Office contact: _____

Address: _____ City: _____ State:_____ Zip:_____

MD specialty: _____

MD signature:_____ **Date:** _____