Subcutaneous Immune Globulin (Subq Ig) 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 Subq Ig? Yes ☐ No ☐ Which product? _____ When? _____

Is patient diabetic? Yes ☐ No ☐ Is patient new to Subq 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:

_____ Grams of Subq Ig to be infused as directed once weekly; **or**

_____ Grams of Subq Ig to be infused as directed every other week; **or**

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 Subq Ig dose:

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

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

Prescriber: _____ Phone number: _____ Fax number: _____

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

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

MD specialty: _____

MD signature:_____ **Date:** _____