



Subcutaneous Immune Globulin (Subq Ig) Referral Form

Patient name: _____ Address: _____

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

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 No Is patient new to Subq Ig?

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

Weight: _____ kg lbs DOB: _____ Male Female

***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. ***Per AIC Protocol, an ANAPHYLAXIS KIT will be provided.**

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

Acetaminophen 650mg PO Diphenhydramine 25mg None Other: _____

***AIC/ANS to provide 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: _____