Advanced Infusion Care

Intravenous Immune Globulin (IV) 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 Ig? Yes ☐ No ☐ Which product? _____ When? _____

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

Known Allergies? Yes ☐ 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:

_____gm/kg/day IV for _____ days every _____ weeks to be administered via peripheral IV ☐ or Life Port ☐

_____ gm/day IV for _____ days every _____ weeks to be administered via peripheral IV ☐ or Life Port ☐

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 Ig dose:

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

***AIC / ANS to provide 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:** _____

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