



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 No Is patient new to 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:

_____ gm/kg/day IV for _____ days every _____ weeks to be administered via peripheral IV or VAD *Include VAD report if applicable

_____ gm/day IV for _____ days every _____ weeks to be administered via peripheral IV or VAD *Include VAD report if applicable

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: _____