

IVI~~G~~ Referral Form



PHONE: 1-800-277-7302 FAX: 1-866-374-6663

Demographics Information: Today's Date _____	
Patient Name: _____ DOB: _____	
Address: _____ City: _____ State: <u>GA</u> Zip: _____	
Phone #: _____ <input type="checkbox"/> Cell Alternate Phone #: _____ <input type="checkbox"/> Cell	
Height: _____ in/ft Weight: _____ lbs/kg Date weight recorded: _____ Last 4 of SSN: _____	
Allergies: _____ <input type="checkbox"/> NKDA	
Diagnosis Information: <input type="checkbox"/> Myasthenia Gravis G70.01 <input type="checkbox"/> Myositis M60.9 <input type="checkbox"/> Multiple Sclerosis G35 <input type="checkbox"/> Kawasaki Disease M30.3 <input type="checkbox"/> Chronic Inflammatory Demyelinating Polyneuropathy G61.81 <input type="checkbox"/> Immune Thrombocytopenia D69.3 <input type="checkbox"/> Lupus M32.10 <input type="checkbox"/> Guillan-Barre Syndrome G61.0 <input type="checkbox"/> Other Diagnosis/ICD10 Code _____	
Date Infusion to Begin: _____	Is this a first infusion? <input type="checkbox"/> YES <input type="checkbox"/> NO
Previous Infusion Reaction: <input type="checkbox"/> YES <input type="checkbox"/> NO	Date of Last Infusion: _____
List Reactions: _____	List of Failed Therapies: _____
Assessment Questions: <i>Please Provide Appropriate Documentation</i>	
Diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No HTN? <input type="checkbox"/> Yes <input type="checkbox"/> No Cardiac History? <input type="checkbox"/> Yes <input type="checkbox"/> No Difficulty Breathing? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Requires Oxygen? <input type="checkbox"/> Yes <input type="checkbox"/> No Confusion /Disorientation? <input type="checkbox"/> Yes <input type="checkbox"/> No Neuro History? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of Negative TB test: _____ Date of Hep B Panel: _____	
IV Immunoglobulin: <input type="checkbox"/> <i>Insurance to Dictate Brand</i> <input type="checkbox"/> <i>Specific Brand</i> _____	
<input type="checkbox"/> _____ Grams IV every _____ weeks for _____ months. Titrate per IVCO policy	
<input type="checkbox"/> _____ Grams/kg IV every _____ weeks for _____ months. Titrate per IVCO policy	
List Prior product if not first dose: _____	
Pre-Medications: Patient to Provide and take 30 minutes prior to infusion	
<input type="checkbox"/> Benadryl 25 MG PO x1 <input type="checkbox"/> Benadryl 50 mg PO x1	
<input type="checkbox"/> Acetaminophen 325 mg PO x1 <input type="checkbox"/> Acetaminophen 650 mg PO x1	
<input type="checkbox"/> Other Pre-medication: _____	
Access: <input type="checkbox"/> PIV <input type="checkbox"/> PORT <input type="checkbox"/> PICC Route: <input type="checkbox"/> IV	Supplies: (please strike through if not required)
Catheter Care/Flush: To gain access, use for any ordered pre-medications, and/or PRN to maintain access and patency	Administration Supplies (A4222) – 1 per infusion
PIV – NS 5ml: Qty 3	Catheter Care Supplies (A4221) – 1 per week
PORT – NS 10ml: Qty 3, Heparin 5mL 100units/mL x 1 per infusion.	Infusion Pump (E0781)
PICC – NS 10ml: Qty 3, Heparin 5mL 10units/mL x 1 per infusion	Nursing services to administer
<i>For insurance compliance, the prescribing physician or PA must sign, no stamps or nurse/NP signatures</i>	
Physician/PA signature: _____	
NPI # _____ Phone Number _____	
Office Address: _____ City: _____ St _____ Zip: _____	
Printed Name: _____ Contact Name: _____	
Please fax this form to our Intake Department along with a copy of Patient's Insurance Card, Demographic information, H & P, Office Visit notes - including supporting documentation for failed therapies, and Up to Date Medication List.	