IVIG Referral Form

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

Demographics Information: Today's Date ___________________

Patient Name: ____ DOB: ___________________________

Address: ____ City: __________________ State: GA Zip: _________

Phone #: ______________________________ ☐ Cell Alternate Phone #: ___________________________ ☐ Cell

Height: _______ in/ft Weight: _______ lbs/kg Date weight recorded: __________ Last 4 of SSN: __________

Allergies: ____ ☐ **NKDA**

Diagnosis Information: ☐ Myasthenia Gravis G70.01 ☐ Myositis M60.9 ☐ Multiple Sclerosis G35 ☐ Kawasaki Disease M30.3 ☐ Chronic Inflammatory Demyelinating Polyneuropathy G61.81 ☐ Immune Thrombocytopenia D69.3 ☐ Lupus M32.10 ☐ Guillan-Barre Syndrome G61.0 ☐ **Other Diagnosis/ICD10 Code**____

Date Infusion to Begin: _________________________

Previous Infusion Reaction: ☐ YES ☐ NO

List Reactions: ________________________________

Is this a first infusion? ☐ YES ☐ NO

Date of Last Infusion: ______________________________

List of Failed Therapies: ____________________________

Assessment Questions: *Please Provide Appropriate Documentation*

Diabetes? ☐ Yes ☐ No HTN? ☐ Yes ☐ No Cardiac History? ☐ Yes ☐ No Difficulty Breathing? ☐ Yes ☐ No
Requires Oxygen? ☐ Yes ☐ No Confusion /Disorientation? ☐ Yes ☐ No Neuro History? ☐ Yes ☐ No
Date of Negative TB test: __________________ Date of negative Hep B Screen: ____________________________

IV Immunoglobulin: ☐ ***Insurance to Dictate Brand*** ☐ ***Specific Brand*** ___________________________
☐________Grams IV every __________ weeks for __________ months. Titrate per IVCO policy
☐________mg/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

☐ Benadryl 25 MG PO x1 ☐ Benadryl 50 mg PO x1
☐ Acetaminophen 325 mg PO x1 ☐ Acetaminophen 650 mg PO x1
☐ Other Pre-medication: ____

Access: ☐ **PIV** ☐ **PORT** ☐ **PICC** **Route:** ☐ **IV**

Catheter Care/Flush: To gain access, use for any ordered pre-medications, and/or PRN to maintain access and patency

PIV – NS 5ml: Qty 10

PORT – NS 10ml:Qty 10, Heparin 5mL 100units/mL x 1 per infusion.

PICC – NS 10ml: Qty 10, Heparin 5mL 10units/mL x 1 per infusion

Supplies: (please strike through if not required)

Administration Supplies (A4222) – 1 per infusion

Catheter Care Supplies (A4221) – 1 per week

Infusion Pump (E0781)

Nursing services to administer

For insurance compliance, the prescribing physician or PA must sign, no stamps or nurse/NP signatures

Physician/PA signature: ____

NPI # _____________________________________ Phone Number _____________________________

Office Address: _______________________________ City: __________________ St GA 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.

05/21 TSP