IVIG Referral Form

PHONE: 1-800-277-7302 FAX: 1-866-374-6663 Email: intakehealthcoga.com ☐ *Initial Order* ☐ *Reorder*

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: _____

Labs Required : IgG : _____ IgA _____

Labs Recommended: BUN _____ Creatinine_____

IV Immunoglobulin: ☐ ***Insurance to Dictate Brand*** ☐ ***Specific Brand*** _____

☐_____Grams IV every _____ weeks for _____ months. Titrate per IVCO policy

☐_____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

☐ 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 3

PORT – NS 10ml: Qty 3, Heparin 5mL 100units/mL x 1 per infusion.

PICC – NS 10ml: Qty 3, 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 medications

Administer the anaphylaxis protocol for adverse reactions

Provider signature: _____

NPI # _____ Phone _____ Fax _____

Office Address: _____ City: _____ St ____Zip: _____

Printed MD Name: _____ Contact Name: _____

☐ Demographic information ☐ Patient Ins. Card ☐ H & P ☐ Office notes ☐ Failed therapies in documentation

☐ Up to date medication list

9/23 TSP