

REFERRAL STATUS		
<input type="checkbox"/> NEW REFERRAL	<input type="checkbox"/> DOSE/FREQUENCY CHANGE	<input type="checkbox"/> ORDER RENEWAL

PATIENT INFORMATION
NAME: _____
DATE OF BIRTH: ____/____/____
PHONE: (____) _____-_____
ALLERGIES: _____ _____
WEIGHT: _____LBS HEIGHT: _____IN
PLEASE ATTACH DEMOGRAPHICS, CLINICALS, AND LABS

PROVIDER INFORMATION
NAME: _____
NPI: _____
SIGNATURE: _____
PHONE: (____) _____-_____
FAX: (____) _____-_____
CONTACT PERSON: _____
DATE: ____/____/____ REFILLS: _____
ALL ORDERS ARE VALID FOR ONE YEAR, UNLESS SPECIFIED

MEDICAL INFORMATION (REQUIRED)
<input type="checkbox"/> IVIG: CBC, CMP, OR BMP; IG SERUM (OPTIONAL)

MEDICATION ORDERS																			
<table style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> GAMUNEX-C <input type="checkbox"/> GAMMAGARD <input type="checkbox"/> PANZYGA <input type="checkbox"/> FLEBOGAMMA 5% <input type="checkbox"/> BIVIGAM <input type="checkbox"/> CYTOGAM </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> OCTAGAM <input type="checkbox"/> GAMMAPLEX <input type="checkbox"/> FLEBOGAMMA 10% <input type="checkbox"/> CARIMUNE _____ % <input type="checkbox"/> GAMMAKED <input type="checkbox"/> PRIVIGEN </td> </tr> </table> <p style="margin-top: 20px;">DOSAGE: _____ GM IV DIVIDED OVER _____ DAY(S) FREQUENCY: EVERY _____ WEEKS</p>	<input type="checkbox"/> GAMUNEX-C <input type="checkbox"/> GAMMAGARD <input type="checkbox"/> PANZYGA <input type="checkbox"/> FLEBOGAMMA 5% <input type="checkbox"/> BIVIGAM <input type="checkbox"/> CYTOGAM	<input type="checkbox"/> OCTAGAM <input type="checkbox"/> GAMMAPLEX <input type="checkbox"/> FLEBOGAMMA 10% <input type="checkbox"/> CARIMUNE _____ % <input type="checkbox"/> GAMMAKED <input type="checkbox"/> PRIVIGEN	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #cccccc;"> <th style="text-align: center; padding: 5px;">DIAGNOSIS</th> </tr> </thead> <tbody> <tr> <td style="padding: 5px;"><input type="checkbox"/> COMMON VARIABLE IMMUNODEFICIENCY ICD-10: _____</td> </tr> <tr> <td style="padding: 5px;"><input type="checkbox"/> OTHER: _____ _____</td> </tr> <tr> <td style="padding: 5px;">ICD-10: _____</td> </tr> </tbody> </table> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr style="background-color: #cccccc;"> <th style="text-align: center; padding: 5px;">PRE-MEDICATIONS</th> </tr> </thead> <tbody> <tr> <td style="padding: 5px;">BENADRYL IV _____ MG</td> </tr> <tr> <td style="padding: 5px;">REGLAN IV _____ MG</td> </tr> <tr> <td style="padding: 5px;">SOLUMEDROL IV _____ MG</td> </tr> <tr> <td style="padding: 5px;">ZOFRAN IV _____ MG</td> </tr> <tr> <td style="padding: 5px;">OTHER IV _____ MG</td> </tr> <tr> <td style="padding: 5px;">BENADRYL PO _____ MG</td> </tr> <tr> <td style="padding: 5px;">TYLENOL PO _____ MG</td> </tr> <tr> <td style="padding: 5px;">ZYRTEC PO _____ MG</td> </tr> <tr> <td style="padding: 5px;">ZOFRAN PO _____ MG</td> </tr> <tr> <td style="padding: 5px;">ZANTAC PO _____ MG</td> </tr> <tr> <td style="padding: 5px;">OTHER PO _____ MG</td> </tr> </tbody> </table>	DIAGNOSIS	<input type="checkbox"/> COMMON VARIABLE IMMUNODEFICIENCY ICD-10: _____	<input type="checkbox"/> OTHER: _____ _____	ICD-10: _____	PRE-MEDICATIONS	BENADRYL IV _____ MG	REGLAN IV _____ MG	SOLUMEDROL IV _____ MG	ZOFRAN IV _____ MG	OTHER IV _____ MG	BENADRYL PO _____ MG	TYLENOL PO _____ MG	ZYRTEC PO _____ MG	ZOFRAN PO _____ MG	ZANTAC PO _____ MG	OTHER PO _____ MG
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