Therapeutics

IVIG

PHONE: 832-813-8932 FAX: 888-883-9901

REFERRAL STATUS

☐ NEW REFERRAL ☐ DOSE/FREQUENCY CHANGE ☐ 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)

☐ IVIG: CBC, CMP, OR BMP; IG SERUM (OPTIONAL)

MEDICATION ORDERS

☐ GAMUNEX-C
☐ GAMMAGARD
☐ PANZYGA
☐ FLEBOGAMMA 5%
☐ BIVIGAM
☐ CYTOGAM
☐ OCTAGAM
☐ GAMMAPLEX
☐ FLEBOGAMMA 10%
☐ CARIMUNE _____ %
☐ GAMMAKED
☐ PRIVIGEN

DOSAGE: _____ GM IV DIVIDED OVER _____ DAY(S)
FREQUENCY: EVERY _____ WEEKS

DIAGNOSIS

☐ COMMON VARIABLE IMMUNODEFICIENCY

ICD-10: _____

☐ 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