

Immunology IVIG Patient Referral Form

Return Signed Rx via fax to (800) 878-4160



Date	Fax #	# of Pages
-------------	-------	------------

Contact	Phone #
----------------	---------

Patient's Name	D.O.B.	Height	Weight
-----------------------	---------------	---------------	---------------

Rx: Intravenous Route <i>(Dose will be rounded to nearest vial size)</i> <input type="checkbox"/> Pharmacy Select <input type="checkbox"/> Specify Brand: _____ _____ grams OR _____ grams per kg OR _____ mg per kg Every _____ weeks <input type="checkbox"/> Divide total dose over _____ days <input type="checkbox"/> Refill for _____ months.	Rx: Subcutaneous Route <i>(Dose will be rounded to nearest vial size)</i> <input type="checkbox"/> Pharmacy Select <input type="checkbox"/> Specify Brand: _____ _____ grams OR _____ grams per kg OR _____ mg per kg <input type="checkbox"/> Once weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Other _____ <input type="checkbox"/> Refill for _____ months.
---	---

Diagnosis: <input type="checkbox"/> D80.1 Hypogammaglobulinemia, unspecified <input type="checkbox"/> D80.2 IgA Immunodeficiency <input type="checkbox"/> D80.3 Other selective Ig deficiencies <input type="checkbox"/> D80.4 IgM Immunodeficiency <input type="checkbox"/> D80.5 Immunodeficiency with increased IgM <input type="checkbox"/> D81.9 Combined immunity deficiency Agammaglobulinemia	<input type="checkbox"/> D82.0 Wiskott-Aldrich syndrome <input type="checkbox"/> D83.0 Deficiency of cell-mediated immunity <input type="checkbox"/> D83.1 Immunodeficiency with predominant T-cell defect, unspecified <input type="checkbox"/> D83.8 or 83.9 Common variable immunodeficiency: acquired; primary <input type="checkbox"/> Other: _____
--	--

IV Access Device: Peripheral Central Hydration: Infuse _____ ml of NS or D5W.

Premedication Orders: <input type="checkbox"/> Acetaminophen 650mg (325mg x 2) <input type="checkbox"/> Oral / <input type="checkbox"/> IV <input type="checkbox"/> Diphenhydramine 25mg <input type="checkbox"/> Orally / <input type="checkbox"/> IV <input type="checkbox"/> Solu Medrol® _____ mg slow IVP <input type="checkbox"/> Other _____ Additional Orders: <input checked="" type="checkbox"/> Anaphylaxis Protocol Kit <input type="checkbox"/> Epi-pen 0.3mg two (2) pack. Auto-injector if self infused.	If Applicable, flush intravenous access device per Comfort Infusion protocol: <table border="1" style="width:100%; border-collapse: collapse; margin-top: 5px;"> <thead> <tr> <th style="width:30%;">Access</th> <th style="width:35%;">NS</th> <th style="width:35%;">Heparin 100u/ml</th> </tr> </thead> <tbody> <tr> <td>Peripheral</td> <td>5-10 ml before/after use</td> <td>3-5 ml after last NS</td> </tr> <tr> <td>Midline, Central (Non-port) PICC</td> <td>10 ml before/after use 10 ml before/after blood draw</td> <td>5 ml after last NS</td> </tr> <tr> <td>Implanted Port</td> <td>10 ml before/after use 10-20 ml before/after blood draw</td> <td>5 ml after last NS</td> </tr> <tr> <td>Groshong PICC, Midline</td> <td>10 ml before/after use 10-20 ml before/after blood draw</td> <td>None</td> </tr> </tbody> </table>	Access	NS	Heparin 100u/ml	Peripheral	5-10 ml before/after use	3-5 ml after last NS	Midline, Central (Non-port) PICC	10 ml before/after use 10 ml before/after blood draw	5 ml after last NS	Implanted Port	10 ml before/after use 10-20 ml before/after blood draw	5 ml after last NS	Groshong PICC, Midline	10 ml before/after use 10-20 ml before/after blood draw	None
Access	NS	Heparin 100u/ml														
Peripheral	5-10 ml before/after use	3-5 ml after last NS														
Midline, Central (Non-port) PICC	10 ml before/after use 10 ml before/after blood draw	5 ml after last NS														
Implanted Port	10 ml before/after use 10-20 ml before/after blood draw	5 ml after last NS														
Groshong PICC, Midline	10 ml before/after use 10-20 ml before/after blood draw	None														

LAB ORDERS
 If needed, a Basic Metabolic Panel (Chem 7) to be drawn prior to first dose.

NURSING ORDERS
 RN to infuse IVIG x _____ days every _____ week(s) and as needed. RN to provide initial education and PRN visits as needed.

If necessary Patient may have first dose administered in the home by a skilled nurse, unless instructed otherwise. Pharmacy to provide all equipment and medical supplies necessary to administer therapy as appropriate.

Prescriber Signature: _____ **Date:** _____ **NPI #** _____
 Prescriber following patient if different from above: _____

Please fax the following information

- Immunoglobulin order - include dose, route of administration, frequency, duration, and any premedications OR use Rx order section above
- Patient demographics - include insurance information. We will obtain authorization, unless the insurance dictates otherwise.
- H & P OR progress note(s) describing diagnosis and clinical status
- Labs - BUN/Creatinine (preferred within last 90 days), Immunoglobulin Panel

CONFIDENTIALITY NOTICE: The following includes confidential, proprietary information that is the sole exclusive property of Vital Rx. No rights in, relating to, or derived from such information are assigned or otherwise transferred by this document, and the recipient of such information is subject to obligations of secrecy to and for the benefit of Vital Rx. Any unauthorized use or disclosure of such information is strictly prohibited. This message, together with any attachments, is intended only for the use of the individual or entity to which it is addressed and may contain information that is confidential and prohibited from disclosure. If you are not the intended recipient, you are hereby notified that any dissemination, or copying of this message, or any attachment, is strictly prohibited. If you have received this message in error, please notify the original sender immediately by telephone or by return fax and shred this document along with any other documents. Thank you.