

Immunology immunoglobulin referral form

Phone: 1-877-342-9352

Fax: 1-888-594-4844

PATIENT INFORMATION

IG specialist: Name		Phone:	Patient: <input type="checkbox"/> see attached Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Patient name:		DOB:	SSN:	
Address:			City:	
State:	ZIP:	Phone:	Cell:	
Emergency contact:		Phone:	Relationship:	
Insurance: <input type="checkbox"/> Front and back of insurance card to follow				
Primary Insurance:		Phone:	Policy #:	Group:
Secondary Insurance:		Phone:	Policy #:	Group:
Primary diagnosis: <input type="checkbox"/> Combined immunodeficiency <input type="checkbox"/> Common hypogammaglobulinemia <input type="checkbox"/> Common variable immunodeficiency <input type="checkbox"/> Immune thrombocytopenic purpura <input type="checkbox"/> Immunodeficiency with increased IgM <input type="checkbox"/> Wiskott-Aldrich syndrome <input type="checkbox"/> Other:				
Medical assessment: Height: Weight: <input type="checkbox"/> lbs <input type="checkbox"/> kg				
Current medications? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list or attach:				
Allergies:				

PRESCRIPTION ORDERS Medication infused per PI recommended rate and via rate controlled device per therapy

Immune Globulin: <input type="checkbox"/> No preference <input type="checkbox"/> Preferred product:				
Directions: <input type="checkbox"/> Infuse IV <input type="checkbox"/> Infuse SC <input type="checkbox"/> Per manufacturer guidelines or as written: <input type="checkbox"/> May round to the nearest 5mg vial size				
Initial: gm/kg divided over days; OR <input type="checkbox"/> Other:				
Ongoing: gm/kg divided over days, every weeks for cycles; OR <input type="checkbox"/> Other:				
Quantity/Refills: 1-month supply; refill x 12 months unless otherwise noted <input type="checkbox"/> Other:				
Pre-medications 30 minutes before start of IG:				
<input type="checkbox"/> Acetaminophen PO <input type="checkbox"/> 325 mg <input type="checkbox"/> 650 mg <input type="checkbox"/> mg <input type="checkbox"/> DiphenhydrAMINE PO <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg <input type="checkbox"/> mg				
<input type="checkbox"/> Hydration, solution: Volume: mL/hr: <input type="checkbox"/> Other:				
Nursing and other orders:				
<input type="checkbox"/> Administer IVIG or teach SCIG self-administration, via pump <input type="checkbox"/> Ambulatory pump if required for infusion				
<input type="checkbox"/> Initiate access device (<i>insert peripheral IV, SC needles, access implanted port, or use existing PICC</i>)				
<input type="checkbox"/> Flush IV with 5mL 0.9% NaCl; Heparin 100 units/mL OR 10 unit/mL, 3-5mL PRN				
<input type="checkbox"/> Obtain labs (list): Lab frequency: <input type="checkbox"/> Once <input type="checkbox"/> Monthly <input type="checkbox"/> Other:				
<input type="checkbox"/> Anaphylaxis kit order Infusion Reaction Management x1 year				
Mild	<ul style="list-style-type: none"> • Slow infusion rate by 50% until symptoms resolve. Resume at previous rate as tolerated. <input type="checkbox"/> DiphenhydrAMINE PO <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg <input type="checkbox"/> mg Dispense diphenhydrAMINE 25mg capsules x 4 			
Moderate	<ul style="list-style-type: none"> • Stop Infusion, resume at 50% rate when symptoms resolve <input type="checkbox"/> DiphenhydrAMINE IV <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg <input type="checkbox"/> mg Dispense diphenhydrAMINE 50mg vial x 1 			
Severe (Anaphylaxis) *Call 911* Notify prescribing physician	<ul style="list-style-type: none"> • Stop infusion and remove tubing from access device to prevent further administration • Initiate 0.9% NaCl 500mL/hr IV OR mL/hr <input type="checkbox"/> Dispense 0.9% NaCl 500mL x 1 • Administer EPINEPHrine 1mg/mL by weight (Wt.) as an IM injection into the lateral thigh Wt > 66lbs (30kg) Wt 33 to 66 lbs (15 to 30kg) Wt < 33lbs (15kg) 0.3mg/0.3mL 0.15mg/0.15mL 0.01mg/kg • Repeat EPINEPHrine in 5 to 15 minutes if symptoms persist • Administer CPR if needed until EMS arrives <input type="checkbox"/> Dispense EPINEPHrine x 2: <input type="checkbox"/> 1mg vial <input type="checkbox"/> Pen JR 0.15mg <input type="checkbox"/> Pen 0.3mg <input type="checkbox"/> Other: 			

PHYSICIAN INFORMATION

Name:		Practice:		
Address:		City:	State:	ZIP:
Phone:	Fax:	NPI:	Contact:	
By signing, I certify/recertify that the above therapy, products and services are medically necessary and that this patient is under my care. I have received authorization to release the above referenced information and medical and/or patient information relating to this therapy. Pharmacy has my permission to contact the insurance company on my behalf to obtain authorization for patient.				
Substitution permissible Signature:		Date	Dispense as written Signature:	