FAX to +1 208.963.3245 or Email to intake@infusionspecialists.org
To ensure processing of your order, please complete all fields.

INFUSION SPECIALISTS

IVIG REFERRAL FORM

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

• Insurance Card • H&P • Patient Dems • Most Recent Labs • Med List • Current IG Levels

PRIMARY DIAGNOSIS

☐ C91.0 Acute lymphoblastic leukemia [ALL]
☐ D80.1 Nonfamilial hypogammaglobulinemia
☐ D80.3 Selective deficiency of immunoglobulin G [IgG] subclasses
☐ D80.9 Immunodeficiency with predominantly antibody defects, unspecified
☐ D83.0 Com variable immunodeficiency w/ predominant abnlt of B-cell nums & function
☐ D83.1 Com variable immunodefiency w/ predominant immunoreg T-cell disorders
☐ D83.9 Common variable immunodeficiency, unspecified
☐ G35 Multiple sclerosis
☐ G61.81 Chronic inflammatory demyelinating polyneuritis
☐ G61.82 Multifocal motor neuropathy
☐ G70.00 Myasthenia gravis without (acute) exacerbation
☐ G70.01 Myasthenia gravis with (acute) exacerbation
☐ G72.49 Oth inflammatory and immune myopathies, NEC
☐ J84.9 Interstitial pulmonary disease, unspecified
☐ L10.0 Pemphigus vulgaris
☐ M33.13 Other dermatomyositis without myopathy
☐ M33.20 Polymyositis, organ involvement unspecified
☐ M33.22 Polymyositis with myopathy
☐ M33.90 Dermatopolymyositis, unspecified, organ involvement unspecified
☐ M72.6 Necrotizing fasciitis
☐ T86.10 Unspecified complication of kidney transplant
☐ T86.11 Kidney transplant rejection
☐ Z94.0 Kidney transplant status
☐ Other: _____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

☑ Per infusion clinic protocol: No recommended standard pre-meds for IVIG
☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

No Brand Preference:
☐ No brand preference - Immune Globulin Solution 5%
☐ No brand preference - Immune Globulin Solution 10%

If Brand Preference:
☐ Gamunex-C 10%
☐ Gammagard Liquid 10%
☐ Octagam 5%
☐ Octagam 10%
☐ Privigen 10%
☐ Bivigam 10%
☐ Panzyga 10%
☐ Other _____

Dosing:
☐ _____GRAMS/kg or _____GRAMS IV divided equally over _____days every _____weeks
☐ _____milligrams/kg or_____milligrams IV divided equally over _____days every _____weeks
☐ Other: _____

*Dose will be rounded to the nearest 5g vial size. To prohibit dose rounding, check here ☐
First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted: _____

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per Infusion Specialists' protocol (See infusionspecialist.org for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion reaction and anaphylaxis medications per Infusion Specialists' protocol (See infusionspecialist.org for detailed policy)
☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

Provider Signature _____ Date _____