

IVIG Referral Form



REQUIRED INFORMATION

- ☐ This signed order form from the provider
- ☐ Patient demographics and insurance information
- ☐ Clinical/Progress Notes, Labs, and Tests supporting primary diagnosis (ICD-10 below)

Patient Name:	DOB:	Weight:
Allergies:	Patient Phone:	
Diagnosis and ICD-10:		
☐ Pharmacist to identify clinically appropriate brand/infusion rates. May substitute based on product availability. ☐ Do not substitute. Administer brand: _____ Loading Dose: _____ ☐ mg/kg IV x _____ day(s) OR divided over _____ day(s) ☐ g/kg ☐ grams Maintenance Dose: _____ ☐ mg/kg IV x _____ day(s) OR divided over _____ day(s) ☐ g/kg ☐ grams Frequency: Every _____ week(s) OR ☐ one time dose Refill: ☐ PRN x 1 year OR _____ times Protocol Pre-Medication Orders: ☐ Acetaminophen 650 mg PO OR ☐ Acetaminophen 1000 mg PO ☐ Diphenhydramine 25 mg PO OR ☐ Cetirizine 10 mg PO Additional Pre-Medication Orders: ☐ Solu-Medrol _____ mg IV ☐ NS 0.9% _____ mL IV ☐ Zofran 4 mg IV ☐ Other: _____ Supply Orders: ☐ Pharmacy to provide all supplies needed to complete therapy as prescribed ☐ May use Burnham's Vital Care flush and catheter maintenance protocol Nursing Orders: ☐ Pharmacy to provide nursing services, including vascular access, administration, and line care ☐ May use Burnham's Vital Care anaphylaxis protocol Additional Instructions/Labs:		
Practitioner Name:	Practitioner Signature:	Date:
Practitioner Address:		

ALABAMA

2724 Old Shell Rd | Mobile, AL 36607

☎ 251-460-1010 | 🏠 251-301-9779

MISSISSIPPI

4931 Main Street | Moss Point, MS 39563

☎ 228-474-4663 | 🏠 228-474-5545