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:		