

SCIG 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)
- ☐ Documentation of any tried and failed therapies

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: _____ Dose: ☐ 100 mg/kg subcutaneous IG to be administered via syringe pump ☐ 150 mg/kg ☐ 200 mg/kg ☐ 400 mg/kg ☐ _____ mg/kg Frequency: ☐ weekly ☐ every 2 weeks ☐ every _____ weeks ☐ one time Refill: ☐ PRN x 1 year OR _____ times dose ☐ Adjust dose or frequency to maintain IgG concentration >500 to 700 mg/dL and/or based on response to therapy. *Consistent IgG trough concentrations are typically achieved after 3 to 6 months of regular therapy. 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: ☐ EMLA Cream (Lidocaine 2.5% / Prilocaine 2.5 %) 30 g to use topically on injection site prior to needle insertion ☐ Other: _____		
Supply Orders: ☐ Pharmacy to provide all supplies needed to complete therapy as prescribed		
Nursing Orders: ☐ Pharmacy to provide nursing services for initial administration and teaching and as needed		
☐ May use Burnham's Vital Care anaphylaxis protocol as needed		
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