Advanced InfusionCare™

Intravenous Immune Globulin (IV) Referral Form

Patient Name: ______________________________ Address: ______________________________

City: ____________ State: ____ Zip: ______ Home Phone: __________ Cellular Phone: __________

Work Phone: __________ Emergency Contact: ____________________ Phone: ______________

ICD-10 Codes: ________/________/________/________/________

Has the patient previously received Ig? Yes No Which product? ____________ When? ____________

Is patient diabetic? Yes No No Is patient new to Ig?

Known Allergies? Yes No No If Yes, please list: ______________________________

Weight: ________ kg lbs DOB: ____________ Male Female

***To expedite referral processing, please include copy of: 1.) Insurance card, front and back 2.) H&P 3.) Labs 4.) Diagnostic test results**

Orders:

_____gm/kg/day IV for ______ days every _____ weeks to be administered via peripheral IV or Life Port

_____ gm/day IV for ______ days every ______ weeks to be administered via peripheral IV or Life Port

Other: ____

Product choice: ____________________

Refill x ____ months, dispense 1 month supply. Infuse per Mfr. guidelines unless otherwise ordered. ***Per AIC Protocol, an ANAPHYLAXIS KIT will be provided.**

Pre-medications to be given 30 minutes prior to each Ig dose:

Acetaminophen 650mg PO Diphenhydramine 25mg IV PO None Other: ____________________

***AIC / ANS to provide nursing or arrange patient/caregiver education as needed.**

Labs:

IgG trough in 3 months, then every 6 months; **or**

IgG trough every 6 months; **or**

Other: ____

Prescriber: ____________________ Phone Number: ______________ Fax Number: ______________

DEA#: ______________ NPI#: ______________ Office Contact: ____________________

Address: ____________________ City: ____________________ State: ____ Zip: ____________

MD Specialty: ____________________

MD Signature: ____________________ **Date**: ____________

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