Subcutaneous Immune Globulin (Subq Ig) 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 Subq Ig? Yes No Which product? ______________________ When?_________________

Is patient diabetic? Yes No No Is patient new to Subq 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:

_____Grams of Subq Ig to be infused as directed once weekly; **or**

_____ Grams of Subq Ig to be infused as directed every other week; **or**

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 Subq Ig dose:

Acetaminophen 650mg PO Diphenhydramine 25mg None Other: _________________________________

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

Prescriber: _____________________________________ Phone number: ________________________ Fax number: ________________________

DEA#: ____________________________ NPI#: _____________________ Office contact: ____

Address: _______________________________________ City: _________________________________ State: ____ Zip: _________________

MD specialty: ______________________________________

MD signature: _______________________________________ Date: _______________________

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v.9.7.22