IVIG Referral Form

Patient Preferred Clinic (select one): _____

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

DOB: Patient Name: Patient Phone:

Patient Address: Patient Email:

☐ NKDA Allergies: Weight (lbs/kg): Height:

ICD-10 code (required): ICD-10 description: Last Treatment Date: Last 4 SSN:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ Infusion to be administered per VIVO protocols.

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ CRP ☐ at each dose ☐ every _____
☐ OTHER

PREMEDICATIONS

☐ acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 125mg IV
☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV
☐ Other: _____
Dose: _____ Route: _____
Frequency: _____

IVIG THERAPY ADMINISTRATION

☐ Gammagard ☐ Privigen
☐ Octagam ☐ Bivigam
☐ Gamunex-C ☐ Asceniv

Dosing: _____

Interval: _____

Pre/Post Hydration Orders (optional)

REQUIRED DOCUMENTATION

☐ **Patient Demographics**
☐ **Insurance Card/Information**
☐ **Progress Notes Supporting DX**
☐ **Medication List and H&P**
☐ **Serum Creatinine** *(within last 3 months if treatment naive)*

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions. **Order is valid for one year unless otherwise noted**

Provider Name (Print) **Provider Signature** **Date**

Have a Question? (212) 776-9090

Email Referrals To: info@specialtyinfusion.com

Fax Referrals To: (800) 540-1852

E-Prescribe: QuickRx 2nd Ave, 2355 2nd Avenue, New York NY 10035 Tel: 212-858-0659

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