

IVIG Referral Form



Preferred Clinic (select one):

☐ New Referral ☐ Updated Referral ☐ Referral Renewal

PATIENT INFORMATION

DOB:	Patient Name:	Patient Phone:
Patient Address:	Patient Email:	
☐ NKDA Allergies:	Weight (kg):	Height:
ICD-10 Code (required):	ICD-10 Description:	Last Infusion Date:
		Last 4 Digits SSN:

PROVIDER INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:
Physician Preferred Method of Contact:	☐ Email:	☐ Fax:	☐ Phone:

STANDING ORDERS

☒ Infusion to be administered per Vivo protocols.

LABORATORY ORDERS

☒ **Clinic Specimen Collection Authorization: If required labs are not received prior to appointment, infusion clinic staff are authorized to draw required labs under the referring provider's NPI and route results back to the referring office.**

- ☐ CBC w/ diff every _____
- ☐ CMP 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: _____

PRE/POST HYDRATION ORDERS (optional)

IVIG ADMINISTRATION

IVIG _____ gm/kg/day IV x _____ days every _____ weeks

IVIG _____ gm/kg IV divided over _____ days every _____ weeks

IVIG _____ grams IV x _____ days every _____ weeks

Other _____

Calculated Dose (to be done by Vivo Infusion) _____

Dose will be rounded up to nearest 5-gram vial

☐ Vivo Infusion will select product based upon payer requirements, indication and product availability.

☐ Infuse specific product (subject to authorization):

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)

Provider Name (Print)	Provider Signature	Date
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Email Referrals To: referrals@vivoinfusion.com OR Fax Below

Have a Question? Call (720) 902-4111

Colorado: 303-418-4679	Massachusetts: 781-202-1629	New Jersey: 609-955-3711	Oklahoma: 918-770-4421	Virginia: 804-500-5941
Connecticut: 203-724-4838	Michigan: 833-957-2188	New York: 800-540-1852	Pennsylvania: 215-399-9244	Wisconsin: 414-600-5383
Florida: 904-930-4211	Minnesota: 763-290-0903	Ohio: 216-400-0674	Texas: 469-340-0044	

Referral is valid for one year unless otherwise noted.

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions.

Revision Date 10/2026