IVIG Rheumatology Referral Form

Fax# 844-635-5250

Patient Information

Patient Name: ____ Date:________________ SS#: ___________________

Address: ____ City: _______________________ State: ______Zip________

Phone(day): _________________________ Phone (night): _______________________ DOB: ___________________________

Sex: Male ____ Female ____ Height _________ Medication Needed By: ____________________________

Rx Insurance: _______________________ ID #: __________________ Group #: _________________ Phone:_______________

Medical Insurance: ______________________ ID #: __________________ Group #: _________________ Phone :_____________

Medical Assessment

Diagnosis (ICD-10):

___ Chronic Inflammatory Demyelinating Polyneuropathy (G62.81)
__ _ Critical Illness Polyneuropathy / Acute Motor Neuropathy (G62.81)
___ Lambert – Eaton Myasthenic Syndrome (G73.3)
___ Multiple Sclerosis (G35)
___ Polymyositis (M33.20)
___ Stiff Person Syndrome (G25.82)
___ Acute Infective Polyneuritis / Guillain –Barre Syndrome (G61.0)
___ Dermatomytosis (M33.90)
___ Multifocal Motor Neuropathy (G61.9)
___ Pemphigus Foliaceus / Pemphigus Vulgaris (L10.0)
___ Myasthenia Gravis (G70.0)
___ Other: ____

Allergies: ____

Is this the first dose? ___ Yes ___ No If No, date first dose given: _________ Target Start Date: ________

Vascular Access: ___ Peripheral ___ PICC ___ Port ___ Other: ________________________________

Medication

Patient's Current Weight: ______ lbs

Administer IVIG **Product:** ☐ **Pharmacist to Determine (or)** ☐ **Brand:** ___________________________

Dosage:

☐ Loading Dosage: Infuse _____ grams /kg via pump over _____ days.

☐ Maintenance Dosage: Infuse ______ grams/kg via pump every ________ weeks **Refills:** _______

☐ Other Regimen: ____

Hizentra ☐ Infuse ______ grams / kg via Freedom 60 pump weekly. **Refills:** ________

☐ Other Regimen: ____

Anaphylactic Reactions: Kits will be provided containing the following items.

IVIG: Epinephrine vial 1:1000 (1mg / ml) syringe, Diphenhydramine 25 mg capsules and 50 mg / ml 1 ml, 0.9% NaCL 500 ml bag
SIG: U.D. PRN Anaphylaxis

or

Sub-Q IG: Epipen 0.3mg / 0.3 ml Auto Injector – SIG: U.D. PRN Anaphylaxis

Flushing Protocol:

Adult – Normal Saline (5ml) Sig: 3-5 ml IV pre / post + prn -and- Heparin 100 units / ml (5ml) Sig: 3-5 ml IV post

Child - Normal Saline (5ml) Sig: 3-5 ml IV pre / post + prn -and- Heparin 10 units / ml Sig: 3ml IV post

Pretreatment Orders:

___ APAP __ 325mg or __ 500mg PO 15-30 minutes before infusion.
___ Diphenhydramine 25mg PO 15-30 minutes before infusion.
___ Aspirin 325mg PO 15-30 minutes before infusion.
___ Other: ____

Physician Prescription Orders

Physician Name: ___________________________Date: ______________ Phone: _____________________ Nurse:______________

Clinic: __________________________ Fax: ______________________ License #:__________________ DEA #: _______________

Physician Signature: ____ Date: ___________________________

Substitution permitted