IVIG (immune globulin) Referral Order Form

Fax 888.615.1445

Precisionhc
clinically advanced infusion care
WWW.PRECISIONHC.COM
Phone: 615.367.1444 FAX: 888.615.1445

☐ New Referral ☐ Restart ☐ Medication/ Order Change (New Order Required) ☐ Benefits Verification Only ☐ Refill / Renewal

Precision Healthcare can accept only original prescription drug orders from patients, and faxed prescriptions from the prescribing practitioners.

PATIENT INFORMATION

Name: _____

DOB: _____ SS# _____

Phone # _____

Email: _____

PHYSICIAN INFORMATION

Referring Physician: _____

Practice Address: _____

_____

Office Contact: _____

Contact Phone # _____ Contact Fax # _____

NPI / TIN: _____ _____

IVIG MEDICATION ORDERS

Please choose one (all 10% formulas):

☐ Gammagard ☐ Octagam ☐ Gamunex-C ☐ Privigen ☐ Gammaked ☐ Other (Please specify): _____

Patient Weight: _____**kg** For dosage purposes use: ☐ Actual Body Wt ☐ Ideal Body Wt ☐ Adjusted Body Wt

IVIG Loading dose: _____ GM/Day x _____ days; **OR** _____ GM/KG/COURSE divided over _____ days

IVIG Maintenance dose: _____ GM/Day x _____ days; **OR** _____ GM/KG/COURSE divided over _____ days

Repeat Course every _____ week(s) OK to round to nearest 5 gm vial size

**If multiple doses, consecutive days are preferred, but may schedule non-consecutive days if needed OR

☐ decline (Only use consecutive days)

Refills x 1 year (unless otherwise specified)

INDICATION/DIAGNOSIS (required)

***ICD-10 Code/Description** _____

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Premedications: (If desired, please choose):

☐ Diphenhydramine ☐ 25mg PO ☐ 50mg PO or ☐ 25mg IV ☐ 50mg IV

☐ Acetaminophen ☐ 650 mg PO or ☐ 1000 mg PO

☐ Other: please specify _____

_____ _____

Referring Physician's Signature Date

May use Precision Allergy Reaction Protocol

LAB ORDERS FOR PRECISION NURSING TO DRAW (please specify)

Orders: _____

Frequency: _____

NOTES (ADDITIONAL INFO OR ORDERS)

REQUIRED DOCUMENTATION

☐ Recent Office notes (along with any therapies tried & outcomes) ☐ Current Medication List ☐ History & Physical Report

☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet ☐ Allergies

ATTACH REQUIRED LAB RESULTS (For New Referrals Only)

☐ Serum creatinine w/ eGFR

☐ Comprehensive Metabolic Panel, CBC with differential w/in past 3 months

☐ Antibody testing results and IgA level

As appropriate: ☐ Nerve Conduction Study results, include velocities

☐ Biopsy results

☐ Electromyography (EMG) results

☐ CSF studies

APPOINTMENT DATE AND TIME _____

11.2019