Sarah Bush Lincoln

NOTE: PLEASE COMPLETE ELECTRONIC VERSION, PRINT AND FAX .... Handwritten forms will not be accepted.

PATIENT INFORMATION

Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)

Preferred Location* ☐ Mattoon ☐ Effingham

*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.

Diagnosis and ICD 10 CODE

Diagnosis: ICD 10 Code:

REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)

☐ This signed order form by the provider
☐ Patient demographics AND insurance information
☐ Baseline CMP and CBC
☐ Urinalysis
*Patient may be required to submit a pregnancy test prior to treatment

☐ Clinical/Progress notes supporting primary diagnosis (must be within 1 year)
☐ Labs and Tests supporting primary diagnosis
☐ Hep B; pneumococcal or DT AB titers and other viral testing as per provider

List Tried & Failed Therapies, including duration of treatment:
1) 2)

PREMEDICATION / PREHYDRATION

☐ Tylenol	☐ 650mg ☐ 1000mg	PO	30-60 minutes prior to IVIG
☐ Benadryl	☐ 25mg ☐ 50mg	☐ PO ☐ IVP	30-60 minutes prior to IVIG
☐ Hydration needed	Fluid _____	Volume	Rate:
☐ Other:			

MEDICATION ORDERS

Dosing Wt for Calculations Ht: Wt: BMI:

IVIG Brand

** (will use Privigen 10% unless otherwise specified)

☐ J1459 Privigen 10%**
☐ Other: _____

Weight-Based Dosing**
(Dose may change with fluctuations in weight)
SELECT ONE**
☐ IBW if BMI ≥ 30kg/M
☐ Actual Body weight

Please indicate frequency in the blank space provided.
☐ 0.4 gm/kg IV frequency: _____
☐ 1 gm/kg IV frequency: _____
☐ 2 gm/kg IV frequency: _____
☐ Other: _____
frequency: _____

NOTE: Pharmacy will round dose to nearest 5g dose

Flat Dosing ☐ _____ gm IV

Duration: ☐ **X 6 months** ☐ **X 1 year** _____ **doses**

ADDITIONAL ORDERS / INFORMATION

Check vital signs every 30 minutes

Do not mix with NS, BUT NS can be used as a back up fluid if reactions occur

PRESCRIBER INFORMATION

Prescriber name :		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date: Time:

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Contact us with questions at:
Fax Completed Form and all documentation to:

☐ MATTOON
1000 Health Center Dr. Ph. 217-258-4150
Suite 204 Fax 217-348-2579
Mattoon, IL 61938

☐ EFFINGHAM
901 Medical Park Dr. Ph. 217-342-7500
Suite 201 Fax 217-342-7499
Effingham, IL 62401

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1168

INFUSION ORDERS - IV IMMUNE GLOBULIN

Clinics Scan to: Physician Orders