Infusion ASSOCIATES

Phone: 616-954-0600 Fax: 616-954-1675

IVIG Infusion

*Please fax a copy of patient's Demographics, Insurance Information, Current Lab Results, H&P, and Current Medications and **Recent Visit Notes***

Referral status: ☐ NEW referral ☐ Dose or frequency change ☐ Order renewal

Date: _____/_____/_____

Patient Name: _____ **DOB**: _____/_____/_____

Allergies: _____ **Patient Weight:** _____lbs / kg **Height:**_____

ICD-10 : _____, _____, _____

Serum IgG level: _____ Date collected: _____

In the past year, what medications for the above diagnosis has the patient tried and failed?
☐ N/A continuation of treatment

Drug	Dose	Dates of use

Labs to be collected: ☐ CBC ☐ BMP ☐ IgG ☐ Other: _____

Lab Frequency: ☐ EVERY infusion ☐ Every OTHER infusion ☐ Other:_____

Pre-Medications:	**Diphenhydramine PO**	25mg or 50mg	☐Yes ☐ No
	Cetirizine PO	10mg	☐Yes ☐ No
	Acetaminophen PO	650mg	☐Yes ☐ No

Intravenous Immune Globulin:

10 % Immunoglobulin solution (_____gm/kg): =_____gm

Frequency:_____Duration:_____

Start Date of Infusion: _____/_____/_____ **End Date of Infusion**: _____/_____/_____

Printed provider name: _____

Provider signature: _____

Office phone number: _____ **Fax number:** _____