IVIG REFERRAL FORM

FLOURISH™ HEALTH GROUP

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

• Insurance Card • H&P • Patient Dems • Most Recent Labs • Med List • Current IG Levels

PRIMARY DIAGNOSIS

☐ ICD-10 (_____)
☐ _____
☐ _____
☐ _____
☐ _____
☐ _____
☐ _____
☐ _____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

☑ Per infusion clinic protocol: No recommended standard pre-meds for IVIG
☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

No Brand Preference:
☐ No brand preference - Immune Globulin Solution 5%
☐ No brand preference - Immune Globulin Solution 10%

If Brand Preference:
☐ Gamunex-C 10%
☐ Gammagard Liquid 10%
☐ Octagam 5%
☐ Octagam 10%
☐ Privigen 10%
☐ Bivigam 10%
☐ Panzyga 10%
☐ Other _____

Dosing:
☐ _____g/kg or _____grams divided equally over _____ days every _____ weeks

☐ Other: _____

*Dose will be rounded to the nearest 5g vial size. To prohibit dose rounding, check here ☐

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted: _____

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per Flourish Health Group's protocol (See flourishhealth.com for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion reaction and anaphylaxis medications per Flourish Health Group's protocol (See flourishhealth.com for detailed policy)
☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

_____ _____
Provider Signature Date