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vitalcare INFUSION SERVICES of ROANOKE

IVIG
INFUSION ORDERS

****REQUIRED INFORMATION****

- ☐ This signed order form from the provider
- ☐ Patient demographics & insurance information
- ☐ **Clinical/Progress Notes, Labs & Tests** supporting primary diagnosis (ICD-10 below)

Patient Name: **DOB:**	**Prescriber Name:**
Address:	**Prescriber NPI:**
City: **State:** **Zip:**	**Address:**
Allergies:	**City:** **State:** **Zip:**
Patient Phone:	**Nurse/Key Contact:**
	Phone: **Fax:**

Diagnosis

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

Pt. Weight _____ kg Pt. Height _____

IVIG ORDERS

IVIG Orders (gm/kg)

Loading Dose IVIG Orders **:** _____gm/kg IV divided over_____day(s) x one time.

Maintenance IVIG Orders **:** _____gm/kg IV divided over _____day(s) every _____weeks. Refill_____

OR

IVIG Orders (total grams)

IVIG _____ total grams over _____day(s) IV every _____weeks. Refill or ☐ One Time

Protocol Pre-Medication Orders:

- ☐ Acetaminophen 1000mg PO
- ☐ Diphenhydramine 25mg PO
- ☐ Diphenhydramine 50mg IV slow push over at least 2 minutes, may dilute in 10mL NS 0.9%
- ☐ NS 0.9% 500mL IV over 30 min - 1 hour
- ☐ Other: _____

Anaphylactic Kit & Flush per protocol

Additional Instructions:

Physician Name:	**Phone:**	**Fax:**
****Physician Signature:**	**Date:**	