smartinfusion THERAPY SERVICES

Phone and Fax: 608-690-7210

www.MySmartInfusion.com

IVIG (Immunoglobulin)

Infusion Order Form

Patient Information

Patient Name: _____DOB: _____ M ☐ F ☐

Allergies: _____

☐ New Treatment ☐ Continuing Treatment Last Treatment Date: _____ Next Due Date: _____

Diagnosis and ICD 10 Code (Required)

☐ Diagnosis: _____ ICD 10 Code: _____

☐ Diagnosis: _____ ICD 10 Code: _____

Required Labs

Most recent CBC & CMP, Current IG Levels (attach results)

As Per Provider

- Hep B - Pneumococcal - DT AB titers - TB test
- Other viral testing: _____

Pre-Medication Orders

Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mg ☐ PO

Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV

Methylprednisolone (Solu-Medrol) ☐ 125mg ☐ IV

Ondansetron (Zofran) ☐ 4mg ☐ 8mg ☐ PO ☐ IV

Hydration needed (list below):

Diluent_____ Volume_____ Rate_____

Other: _____ Route: _____

Dose: _____ Frequency: _____

Nursing

Provide nursing care per Smart Infusion Nursing Procedures, Including reaction management and post-procedure observation.

Special Instructions / Notes

IVIG Medication Order

Patient Weight: _____ KG

If Brand Preference:

☐ Gamunex-C 10% ☐ Gammagard Liquid 10%
☐ Privigen 10% ☐ Octagam 10%
☐ Octagam 5% ☐ Gammaked 10%
☐ Panzyga 10% ☐ Other: _____

Dosing:

☐ _____g/kg ☐ _____mg/kg
divided equally over_____days every _____weeks

☐ Other: _____

Refills:

☐ Zero ☐ 12 months ☐ Other _____

Required Documents

☐ Patient Demographic Sheet
☐ H & P within the past 6 months
☐ Current Medication List
☐ Clinical & Progress Notes (including last infusion note)
☐ Copy of Insurance Card (Front/Back)

Location

☐ Eau Claire ☐ Weston ☐ Middleton

Provider Information

Provider Name: _____ Provider NPI: _____

Office Phone: _____ Office Fax: _____

Provider Signature: _____ Date: _____