Phone and Fax: 608-690-7210
Email: info@MySmartInfusion.com
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 (within 3 months & attach results)

CBC Results _______________________________

CMP 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% ☐ Bivigam 10%
☐ Octagam 5% ☐ Octagam 10%
☐ Flebogamma 5% ☐ Flebogamma 10%
☐ Panzyga 10% ☐ Gammaked 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 and Progress Notes

Provider Information

Provider Name: ____ Provider NPI: ______________________

Office Phone: ____________________________________ Office Fax: ____________________________________

Provider Signature: ____ Date: ____________________