smartinfusion THERAPY SERVICES

Phone: 608-690-7210
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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

Ideal Body Weight: _____ KG

If Brand Preference:

☐ Gamunex-C 10% ☐ Octagam 10%

☐ Octagam 5% ☐ Panzyga 10%

☐ Other: _____

Dosing:

☐ _____g/kg ☐ _____mg/kg

divided equally over_____days every _____weeks

*Doses will be rounded to nearest full vial

☐ 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: _____