METRO INFUSION CENTER

Phone: 877.448.3627

Fax completed form to:
866-507-1164

INFUSION ORDERS — IVIG

Date of referral: ____

Patient Name: ____ Date of Birth: ____

Address: ____

City: ____ State: ____________________ ZIP Code: __________________

Phone: ____ WT (kg): __________________ HT: ____________________(in)

Diagnosis: ____

Allergies: ____

ICD 10 CODE: ____

Please include supporting clinical documentation for specified ICD 10 Code as well as demographic and insurance information. This must be provided to ensure payment by insurance carrier. Please fax with this order form.

IVIG DOSING

- ☐ 400 mg/kg every 4 weeks
- ☐ Specific dose of: ____

Prescribing Physician/RN: ____

Address: ____

Physician Signature: ____

Date: ____

Physician Phone: ____ Fax: _______________________________