MIC | METRO INFUSION CENTER

INFUSION ORDERS- IV IMMUNE GLOBULIN

PATIENT INFORMATION	
Name:	**DOB:**
Allergies:	**Date of Referral:**

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)

Preferred Location*

DIAGNOSIS AND ICD 10 CODE (See attached code listing)

☐ Diagnosis:_____ ICD 10 Code: _____

REQUIRED DOCUMENTATION

☐ This signed order form by the provider	☐ Clinical/Progress notes supporting primary diagnosis
☐ Patient demographics AND insurance information	☐ Labs and Tests supporting primary diagnosis
☐ Baseline BUN/Creatine	☐ Hep B; pneumococcal or DT AB titers and other viral testing as per provider

List Tried & Failed Therapies, including duration of treatment:
1) _____ 2) _____

Premedication/Prehydration if required **(not routinely needed unless the patient has had prior reactions- indicated below)**

☐ Tylenol	☐ 650mg ☐ 1000mg	PO	30-60 minutes prior to IVIG
☐ Benadryl	☐ 25mg ☐ 50 mg	☐ PO ☐IVP	30-60 minutes prior to IVIG
☐ Hydration needed	Diluent_____	Volume_____	Rate: _____
☐ Other:			

MEDICATION ORDERS

Dosing Wt for Calculations Ht:_____Wt:_____BMI:_____

IVIG Brand ****(will utilize Gammagard unless otherwise specified)**	Gammagard 10% ** ☐ Other: _____ ******Use different referral/order for Subcutaneous Immune Globulin******
Weight-Based Dosing** (Dose may change with fluctuations in weight) SELECT ONE ** ☐ IBW if BMI ≥ 30kg/M^2 ☐ Actual Body weight	Please indicate frequency in the blank space provided. ☐ 0.4 gm/kg IV frequency: _____ ☐ 1 gm/kg IV frequency:_____ ☐ 2 gm/kg IV frequency:_____ ☐ Other: _____ frequency:_____
Flat Dosing	☐ _____gm IV

Refills: ☐ **X 6 months** ☐ **X 1 year** ____ **dose**

ADDITIONAL ORDERS

*See infusion rate guideline ***

Check vital signs with each rate change

Do not mix with NS, BUT NS can be used as a back up fluid if reactions occur

PHYSICIAN INFORMATION

Prescribing Physician:		
Office Phone:	Office Fax:	Office Email:
Physician Signature:		Date:

All information contained in this order form is strictly confidential and will become part of the patient's medical record.
Contact us with questions at: [877] 448-3627
Send Completed Form and all documentation to:
Confidential email: Intake@Metroinfusioncenter.com or [866] 507-1164

Revised 12/19/22