INTRAVENOUS IMMUNOGLOBULIN

MIC | METRO INFUSION CENTER

REFERRAL STATUS: ☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

Infusion Office Preference: _____

PATIENT INFORMATION			
Date:	Patient Name:		DOB:
☐ NKDA Allergies:		Weight (lbs / kg):	Height:
Patient Status: ☐ New to Therapy ☐ Continuing Therapy - Last Treatment Date:			Next Due Date:
PROVIDER INFORMATION			
Office Contact Name:	Office Email:		
Prescribing Providers Name:	Provider NPI:		
Office Address:	City:	State:	Zip:
Office Phone Number:	Office Fax Number:		
DIAGNOSIS AND ICD 10 CODE			
☐ Diagnosis	ICD-10 Code:		
REQUIRED DOCUMENTATION/Testing			
☐ This signed order form by the provider ☐ Patient demographics AND insurance info ☐ Clinical/Progress notes supporting primary dx	☐ Labs and Tests supporting primary diagnosis		
PRE-MEDICATION ORDERS			
☐ acetaminophen (Tylenol) ☐ 650mg / ☐ 1000mg PO (prior to infusion)			
☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV (prior to infusion)			
☐ methylprednisolone (Solu-Medrol) 125 mg IV (prior to infusion)			
☐ other: _____			
MEDICATION ORDERS			
MIC will select the product based on payor requirements, product availability, and indication unless otherwise noted.			
☐ IVIG _____gm/kg/day IV x _____days			
☐ IVIG _____gm/kg/day IV divided over _____days			
☐ IVIG _____ _____ (*include dosage, frequency, and other special instructions)			
Refills*: ☐ None ☐ X6 months ☐ X1 year ☐ Other: _____ *(if not indicated order will expire one year from date signed)*			

Provider Name (Print) **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: MICreferral@metroinfusioncenter.com or [866] 507-1164