

INTRAVENOUS IMMUNOGLOBULIN

REFERRAL STATUS: New Referral Dose or Frequency Change Order Renewal
Infusion Office Preference: _____

PATIENT INFORMATION	
Date:	Patient Name:
DOB:	
<input type="checkbox"/> NKDA Allergies:	Weight (lbs / kg):
Height:	
Patient Status: <input type="checkbox"/> New to Therapy <input type="checkbox"/> 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	
<input type="checkbox"/> Diagnosis: _____	ICD10 Code: _____
REQUIRED DOCUMENTATION/Testing	
<input type="checkbox"/> This signed order form by the provider	<input type="checkbox"/> Clinical/Progress notes supporting primary dx
<input type="checkbox"/> Patient demographics AND insurance info	<input type="checkbox"/> Labs and Tests supporting primary diagnosis
List Tried & Failed Therapies 1)	2)
PREMEDICATION ORDERS	
<input type="checkbox"/> acetaminophen (Tylenol) PO <input type="checkbox"/> 500mg <input type="checkbox"/> 650mg <input type="checkbox"/> 1000mg <input type="checkbox"/> diphenhydramine (Benadryl) PO / IV <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg (if route is not circled PO will be administered) <input type="checkbox"/> methylprednisolone (Solu-Medrol) IV <input type="checkbox"/> 60mg <input type="checkbox"/> 100mg <input type="checkbox"/> 125mg <input type="checkbox"/> _____ mg <input type="checkbox"/> Other:	
MEDICATION ORDERS	
MIC will select the product based on payor requirements, product availability, and indication unless otherwise	
SELECT ONE (If not selected MIC will follow ABW dosing)	<input type="checkbox"/> IBW dosing <input type="checkbox"/> Actual Body weight
DOSING	<input type="checkbox"/> 0.4 gm/kg IV divided over _____ day(s) every _____ weeks <input type="checkbox"/> 1 gm/kg IV divided over _____ day(s) every _____ weeks <input type="checkbox"/> 2 gm/kg IV divided over _____ day(s) every _____ weeks <input type="checkbox"/> _____ gm/kg IV divided over _____ day(s) every _____ weeks <input type="checkbox"/> Flat dose _____ gm IV divided over _____ day(s) every _____ weeks
Refills*: <input type="checkbox"/> None <input type="checkbox"/> X6 months <input type="checkbox"/> X1 year <input type="checkbox"/> Other: _____ <i>*(if not indicated order will expire one year from date signed)</i>	

Provider Name (Print)

Physician Signature:

Date:

Fax referral to 866-507-1164 or email to MICreferral@metroinfusioncenter.com

All information contained in this order form is strictly confidential and will become part of the patient's medical record.