Immunology Referral Form (Sub-QIG & IVIG)
Fax #: _____

Patient Information

Patient Name: _____ Date:_____ SS#: _____

Address: _____ City: _____ State: _____Zip_____

Phone(day): _____ Phone (night): _____ DOB: _____

Sex: Male ____ Female ____ Height _____ Weight _____ Medication Needed By: _____

Rx Insurance: _____ ID #: _____ Group #: _____ Phone:_____

Medical Insurance: _____ ID #: _____ Group #: _____ Phone :_____

Medical Assessment

Diagnosis (ICD-10):

___ Common Variable Immune Deficiency (D83.9)
___ Common Immunity Deficiency & SCID (D80.4)
___ Congenital Hypogammaglobulinemia (D80.0)
___ Hypogammaglobulinemia (D80.1)
___ Immunodeficiency with Increased IgM (D80.5)
___ Immunodeficiency with Predominant T-Cell Defect (D83.1)
___ Selective IgA Immunodeficiency (D80.2)
___ Selective IgM Immunodeficiency (D80.4)
___ Other Selective Immunodeficiency (D80.3)
___ Wiscott – Aldrich Syndrome (D82.0)
___ Other: _____

Allergies: _____ **Vascular Access**: ___ Peripheral ___ PICC ___ Port ___ Other: _____

Is this the first dose? ___ Yes ___ No If No, date first dose given: _____ Target Start Date: _____

Medication

Patient Current Weight: _____ lbs

Hizentra ☐ Infuse _____ grams via Freedom 60 pump divided into #_____ doses monthly. **Refills: _____**

☐ Other Regimen: _____

Administer IVIG **Product:** ☐ **Pharmacist to Determine (or)** ☐ **Brand:** _____

Dosage:

☐ Loading Dosage: Infuse _____ grams /kg via pump over _____ days.

☐ Maintenance Dosage: Infuse _____ grams/kg via pump every _____ weeks **Refills: _____**

☐ Other Regimen: _____

Anaphylactic Reactions: Kits will be provided containing the following items.

Sub-Q IG: Epipen 0.3mg / 0.3 ml Auto Injector
SIG: U.D. PRN Anaphylaxis
or
IVIG: Epinephrine vial 1:1000 (1mg / ml) syringe, Diphenhydramine 25 mg capsules and 50 mg / ml 1 ml, 0.9% NaCL 500 ml bag
SIG: U.D. PRN Anaphylaxis

Flushing Protocol:

__Adult – Normal Saline (5ml) Sig: 3-5 ml IV pre / post + prn -and- Heparin 100 units / ml (5ml) Sig: 3-5 ml IV post
__Child - Normal Saline (5ml) Sig: 3-5 ml IV pre / post + prn -and- Heparin 10 units / ml Sig: 3ml IV post

Pretreatment Orders:

___ APAP __ 325mg or __ 500mg PO 15-30 minutes before infusion.
___ Diphenhydramine 25mg PO 15-30 minutes before infusion.
___ Aspirin 325mg PO 15-30 minutes before infusion.
___ Other: _____

*****Please include a copy of the patient's Rx insurance card, face sheet, recent clinical assessment notes, and current medication list*****

Physician Prescription Orders

Physician Name: _____ NPI #: _____ Nurse: _____ Date:_____

Address: _____ Phone: _____ Fax: _____

Physician Signature: _____
Substitution permitted