IVIG Neurology Referral Form

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):

___ Chronic Inflammatory Demyelinating Polyneuropathy (G62.81)
___ Critical Illness Polyneuropathy / Acute Motor Neuropathy (G62.81)
___ Lambert – Eaton Myasthenic Syndrome (G73.3)
___ Multiple Sclerosis (G35)
___ Polymyositis (M33.20)
___ Stiff Person Syndrome (G25.82)
___ Acute Infective Polyneuritis / Guillain –Barre Syndrome (G61.0)
___ Dermatomytosis (M33.90)
___ Multifocal Motor Neuropathy (G61.9)
___ Pemphigus Foliaceus / Pemphigus Vulgaris (L10.0)
___ Myasthenia Gravis (G70.0)
___ Other: _____

Allergies: _____

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

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

Medication

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

Dosage:

☐ Loading _____ g/kg via pump over _____ days.

☐ Maintenance _____ g/kg via pump every _____ weeks (round to the nearest 5 grams). Refills: _____

☐ Other Regimen: _____

Anaphylactic Reactions: Kits will be provided containing the following items.
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: _____Date: _____ Phone: _____ Nurse:_____
Clinic: _____ Fax: _____ License #:_____ DEA #: _____

Physician Signature: _____ Date: _____

Substitution permitted

****By signing this form and utilizing our services, you are authorizing Reliant Healthcare and its employees to serve as you prior authorization designated agent in dealing with medical and prescription insurance companies. ****