Heartland Infusion Pharmacy

Phone: (865) 862 - 4557 www.heartlandinfusion.com Fax: (865) 862 – 4556
Alt. Fax: (865) 867 - 7081

Intravenous Immunoglobulin Order Form

Please fax completed form with patient demographic information, front and back of insurance card (s), recent lab results, and recent office visit notes supporting diagnosis to (865) 862-4556.

Referral Status: ☐ New referral ☐ Dose or frequency change ☐ Order Renewal

PATIENT INFORMATION

Name:

Home Phone: Cell Phone:

Email: Last four Social Security number

DOB: Height: Weight:

Allergies:

ICD-10 Diagnosis Code: Years with Disease:

TB Test (Circle One): Skin Quantiferon Chest Xray Result: Date:

LABORATORY ORDERS

☐ CBC w/ Diff	☐ each infusion	☐ Other	
☐ CRP	☐ each infusion	☐ Other	
☐ CMP	☐ each infusion	☐ Other	
☐ ESR	☐ each infusion	☐ Other	
☐ Hepatic Panel	☐ each infusion	☐ Other	
☐ Renal Panel	☐ each infusion	☐ Other	
☐ Quantiferon TB (annually)		Due:	

☐ Other: _____

Therapy Orders ☐ **Pharmacist to select product** ☐ **Immune Globulin** _____

☐ Administer _____gm at _____mg/kg every _____ weeks via IV; Concentration _____%

Infusion rate: Start _____ ml/hr. Max rate _____ml/hr. Ramp up every _____ minutes by _____ml/hr

☐ Hydration (normal saline): ☐ None ☐ Pre-infusion _____ ml ☐ Post-infusion _____ ml

☐ DAW - Do not round to nearest vial size ☐ Nursing per Heartland Nursing Procedures (incl reaction management)

☐ **Pre-Medications**

☐ Tylenol (acetaminophen) _____ mg PO	☐ No routine pre-medications required
☐ Solu-Medrol (methylprednisolone) _____mg IV	☐ Zyrtec (cetirizine) 10 mg PO
☐ Benadryl (diphenhydramine) _____mg ☐ PO	☐ Claritin (loratadine) 10 mg PO
	☐ IV

☐ Other: _____

PHYSICIAN INFORMATION

Physician's Name:

License #: NPI#: DEA#:

Address:

City: State: Zip:

Office Contact: Email:

Office Phone: Office Fax:

Physician Signature: _____ Date: _____

Patient is being referred to: ☐ Knoxville ☐ Morristown ☐ Kingsport