HEARTLAND INFUSION

Fax to Heartland (1.865.862.4556)
Questions? Call (1.865.862.4557)

IVIG Order Form

Please fax completed form with patient demographics, front and back of insurance card(s), recent lab results, and recent office visit notes supporting diagnosis to 865.862.4556.

Type of Referral: ☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

Location: ☐ Jackson ☐ Knoxville ☐ Morristown ☐ Kingsport

PATIENT INFORMATION

First Name: _____ Last Name: _____ DOB: _____ Gender: (**check one**) ☐ M ☐ F

Home Phone: _____ Mobile Phone: _____

Email: _____ Last 4 of SS#: _____

Allergies: _____ Height: _____ Weight: _____

ICD-10 Diagnosis Code(s): _____ Date of Diagnosis: _____

TB Test (**circle one**): Skin Quantiferon Chest X-ray Result: _____ Date: _____

THERAPY ORDERS

☐ **Heartland to select product (based on clinical necessity, patient insurance, and product availability)**

☐ **Immune Globulin** _____

☐ Administer _____ g/kg OR _____ grams (flat dose); over _____ days; every _____ weeks via IV infusion

- ☐ Infusion rate per manufacturer instructions, OR
- ☐ Infusion rate: Start _____mg/kg/min; Max rate _____mg/kg/min; Ramp up every _____ minutes by _____mg/kg/min

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

☐ DAW - Do not round to the nearest 5 gram vial size

☐ Nursing per Heartland Nursing Procedures (including reaction management)

PRE-MEDICATION

☐ **No routine pre-medications required**

☐ Tylenol (acetaminophen) _____mg PO

☐ Solu-Medrol (methylprednisolone) IV ☐ 40 mg, ☐ 125 mg, ☐ other _____mg

☐ Benadryl (diphenhydramine) _____mg ☐ PO ☐ IV

☐ Other: _____

☐ Zyrtec (cetirizine) 10mg PO

☐ Claritin (loratadine) 10mg PO

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: _____

PRESCRIBER'S INFORMATION

Prescriber Name: _____

License #: _____ NPI: _____ DEA: _____

Address: _____

City: _____ State: _____ Zip: _____

Office Contact: _____

Office Phone: _____ Office Fax: _____

Prescriber's Signature: _____