Mankato Clinic
Together we thrive.

ADULT AMBULATORY INFUSION ORDER

Intravenous Immune Globulin (IVIG)

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Date: _____/_____/_____

*__Please fax a copy of the following patient information__: ☐ Demographics ☐ Insurance Information ☐ Current Lab Results ☐ H & P Relevant to Diagnosis ☐ Last infusion note ☐ Current Medications

PATIENT INFORMATION

Allergies: _____

Weight: _____ lbs/kg Height: _____

Diagnosis: _____

ICD-10: _____

PROVIDER INFORMATION

Printed Provider's Name: _____

Signature: _____

NPI: _____ Date: ____/____/_____

Phone: (____)_____-_____ Fax: (____)____-_____

Office Address: _____

Contact Person: _____

PRE-MEDICATIONS:

Diphenhydramine: ☐ PO ☐ IV ☐ 25 mg ☐ 50mg

Acetaminophen: ☐ PO ☐ 650 mg ☐ 1000 mg

Other: ☐ _____

☐ No Pre-Medications

WAIT TIME AFTER PRE MEDICATIONS:

☐ 20 minutes ☐ 30 minutes ☐ Other: _____ ☐ No wait time

LABS:

☐ CBC w/diff ☐ EVERY infusion ☐ every OTHER infusion ☐ other: _____

☐ Immunoglobulins (IgA, IgM, IgG) ☐ EVERY infusion ☐ every OTHER infusion ☐ other: _____

☐ CMP ☐ EVERY infusion ☐ every OTHER infusion ☐ other: _____

☐ Other: _____ ☐ EVERY infusion ☐ every OTHER infusion ☐ other: _____

☐ No labs needed

IVIG DOSE:

☐ Gamunex-C ☐ Gammaked ☐ Gammagard ☐ Privigen ☐ Octogam

Dose:

IVIG dose/kg: _____ grams/kg

Total IVIG dose ordered: _____ g

Frequency:

☐ One Time Dose

☐ Daily x _____ doses ☐ May saline lock IV during infusions

☐ Give every _____ day(s) for a total of _____ doses

☐ Other: _____