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| ADULT AMBULATORY INFUSION ORDER  **Intravenous Immune Globulin (IVIG)** | **NAME:**  **BIRTHDATE:**    *Affix Patient Identification Label Here* |
| **ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (**  **) TO BE ACTIVE.** | |

**Date: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_**

Patient Information

Provider Information

\***Please fax a copy of the following** □Demographics □ Insurance Information □ Current Lab Results **patient information**: □ H & P Relevant to Diagnosis □ Last infusion note □ Current Medications

Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Provider’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Weight: \_\_\_\_\_\_\_\_\_\_\_\_ lbs/kg Height: \_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

ICD-10: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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

MC2677 (04/22)

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Start Date of Infusion: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_

□ Patient is required to stay 30 minutes post infusion time.

□ Patient is **NOT** required to stay for observation time.