

# General Immunoglobulin Referral Form

## IG specialist information

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

## Patient information

Patient name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Gender:  Male  Female

Emergency contact: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

## Insurance information

Primary insurance: \_\_\_\_\_

Phone: \_\_\_\_\_ Subscriber: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group: \_\_\_\_\_

Prescription drug card: \_\_\_\_\_

Policy #: \_\_\_\_\_ Phone: \_\_\_\_\_

Secondary insurance: \_\_\_\_\_

Phone: \_\_\_\_\_ Subscriber: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group: \_\_\_\_\_

## Primary diagnosis

Diagnosis code: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

\_\_\_\_\_

Other: \_\_\_\_\_

## Medical assessment

Height: \_\_\_\_\_ Weight: \_\_\_\_\_  lbs  kg

Advanced directives?  Yes  No

Kidney or heart disease?

Diabetic What is the current A1c? \_\_\_\_\_ mg/dL

Ambulatory?  Yes  No

Homebound?  Yes  No

Is patient currently on any medications?  Yes  No

List: \_\_\_\_\_

\_\_\_\_\_

Allergies: \_\_\_\_\_

\_\_\_\_\_

## Prescription and orders

Is this the first dose?  Yes  No

If no, list product: \_\_\_\_\_

Date of last infusion: \_\_\_\_\_ Next dose due: \_\_\_\_\_

Administer Ig:  IV  Sub Q

\_\_\_\_\_ gm/kg or \_\_\_\_\_ grams every \_\_\_\_\_ wk(s) for \_\_\_\_\_ cycle(s)

*May round up dose to nearest vial size.*

*Admin Directions: Infuse per package insert or dose rate sheet provided by BriovaRx® Infusion Services*

Collect Care Exchange® data (per BriovaRx Infusion Services protocol)

## Other orders

Pre-medication:

Acetaminophen 325mg; 1-2 tabs every 4-6 hours as needed, not to exceed 8 tabs per day.

Diphenhydramine 25-50 mg orally before infusion as needed.

Other: \_\_\_\_\_

Adverse/anaphylactic reactions (per BriovaRx Infusion Services protocol):

Anaphylaxis kit (per BriovaRx Infusion Services protocol).

Mild reaction give Diphenhydramine 50mg (two tabs), slow infusion. If needed give two additional tabs (50mg).

Moderate reaction give 50mg Diphenhydramine (two tabs) and stop infusion.

Severe reaction with breathing problem give 50mg IV Diphenhydramine; EpiPen; 500ml NaCl 0.9% fluid and call 911.

Nursing:  Start PIV or SQ as required for administration and nurse to administer infusion in home.

Access:  Peripheral  PICC  Port  Other: \_\_\_\_\_

Flushing:  BriovaRx Infusion Services protocol (heparin, 0.9% NaCl, D5W)

Labs: \_\_\_\_\_

## Physician information

Physician: \_\_\_\_\_

Practice: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

NPI: \_\_\_\_\_ Contact: \_\_\_\_\_

By signing, I certify/recertify that the above therapy, products and services are medically necessary and that this patient is under my care. I have received authorization to release the above referenced information and medical and/or patient information relating to this therapy.

Physician signature: \_\_\_\_\_ Date: \_\_\_\_\_  
*(Substitution permissible, signature required)*

Physician signature: \_\_\_\_\_ Date: \_\_\_\_\_  
*(Substitution permissible, signature required)*