Immune Globulin Referral Form

VITAL CARE
Home Infusion Services

Address Line 1
Address Line 2

Phone: Fax: Date:

Demographics

Patient Name:

Address:

City: State: Zip:

DOB: M:☐ F:☐

Phone: 2nd Phone:

SSN: Ht: Wt:

Insurance Information (Attach copy of card, if available)

Primary Insurance:

Member #: Group #:

Policy Holder: Relation:

Secondary Insurance:

Member #: Group #:

Policy Holder: Relation:

Physician Orders (Please check the following)

☐ IVIg: Dose _____ grams/kg/day X _____ days
or _____ grams/kg/day X _____ days

Interval (freq. of therapy): # of refills:

Ig Product: ☐Don't Substitute

Route of Admission: ☐ IV ☐ SC ☐ IM

Access Device: ☐ Peripheral Catheter ☐ Other:

Additional medications to be maintained at infusion site and administered as necessary:

☐ EpiPen Auto-Injector 0.3mg (0.3mL, 1:1000)
Patient weight ≥30kg; inject 0.3mg IM PRN for adverse reaction to IVIG

☐ EpiPen Jr. Auto-Injector 0.15mg (0.3mL, 1:2000)
Patient weight 15-30kg; inject 0.15mg IM PRN for adverse reaction to IVIG

☐ Heparin 100 u/mL 5mL post infusion and PRN

☐ Skilled Nursing visits as required

☐ Standard supplies as needed

Additional Orders/Info: (including lab orders, pre-med, vascular device, supplies, anaphylaxis orders, and nursing:

_____

Diagnosis

☐ G61.81 Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)

☐ D80.0 Congenital Hypogammaglobulinemia

☐ D80.5 Immunodeficiency with increased IgM

☐ D82.0 Wiskott-Aldrich Syndrome

☐ D81.9 Combined Immunity Deficiency

☐ G70.00 Myasthenia Gravis **without acute exac**.

☐ G70.01 Myasthenia Gravis **with acute exac**.

☐ G35 Multiple Sclerosis **relapsing/remitting only**

☐ G60.3 Polyneuropathy Idiopathic, **Progressive**

☐ G61.0 Guillian-Barre Syndrome (acute infective polyneuritis)

☐ G62.89 Multifocal Motor Neuropathy

☐ D83.9 Common Variable Immune Deficiency (CVID)

IgG Level: _____ Date: _____

☐ D80.1 Hypogammaglobulinemia

IgG Level: _____ Date: _____

☐ Other: _____

ICD-10 Code: _____

Prescribing Physician

Name:

Address: *(please include facility name)*

Phone: Fax:

Specialty:

License #: UPIN #:

DEA: NPI:

Signature:

Date: