INTEGRATED CARE SYSTEMS

IMMUNE GLOBULIN
PRIMARY IMMUNE DEFICIENCY
PATIENT REFERRAL FORM

PHONE 800.734.2896
FAX 559.734.6451

Patient Last Name First Name	Referral Date
○ Male ○ Female DOB:	Prescriber
Weight _____ lbs **Height** _____ in	Provider Phone # Fax #
♀ **NKDA** ○ **Allergies** _____	Nurse/Office Contact

PRIMARY DIAGNOSIS

- ○ Common Variable Immunodeficiency with predominant abnormalities of B-cell numbers and function ***D83.0***
- ○ Common Variable Immunodeficiency with predominant immunoregulatory T-cell disorders ***D83.1***
- ○ Common Variable Immunodeficiency with antibodies to B or T-cells ***D83.2***
- ○ Other Common Variable Immunodeficiencies ***D83.8***
- ○ Common Variable Immunodeficiency, unspecified ***D83.9***
- ○ Severe Combined Immunodeficiency with reticular dysgenesis ***D81.0***
- ○ Severe Combined Immunodeficiency with low T and B cells ***D81.1***
- ○ Severe Combined Immunodeficiency with low or abnormal B-cell numbers ***D81.1***
- ○ Hereditary Hypogammaglobulinemia ***D80.0***
- ○ Nonfamilial Hypogammaglobulinemia ***D80.1***
- ○ Immunodeficiency with Increased IgM ***D80.5***
- ○ Selective deficiency of Immunoglobulin A ***D80.2***
- ○ Selective deficiency of Immunoglobulin M ***D80.4***
- ○ Wiskott-Aldrich Syndrome ***D82.0***
- ○ Selective deficiency of Immunoglobulin G subclasses ***D80.3***
- ○ Other _____

PLEASE FAX THE FOLLOWING ALONG WITH THIS ORDER

-Face sheet/Demographics
-H&P
-Labs
-Copy of Insurance Card

We will notify you within 24 hours, once this referral is received

If you do not receive a confirmation please call 1.800.734.2896 or re-fax the referral to 559.734.6451

Thank you for the opportunity to assist in the care of your patient

PHYSICIAN ORDER

Loading Dose Immune Globulin

○ _____ gm/kg or _____ gm

Maintenance Dose Immune Globulin

○ _____ gm/kg or _____ gm

every _____ week x _____ cycle(s)

○ Other _____

○ Infusion Rate over 2 1/2-5 hours, titrate up as tolerated via Curlin pump

Has patient received immune globulin previously?

○ Yes
○ No

Administration

○ **IVIG (Intravenous)**
○ **SQIG (Subcutaneous)**
○ Other _____

IV Access

○ Port
○ Peripheral

○ Pre-medication
Acetaminophen 650mg PO 15-30 minutes before infusion
Diphenhydramine 25mg PO 15-30 minutes before infusion
Aspirin 81 mg PO 15-30 minutes before infusion
Other _____

○ As Needed Meds
NS 1 liter IV daily over 4-6 hours on IVIG days
Ondansetron 8mg (add to NS bags for N/V)
Ondansetron 4mg IV push Q4-6 hours PRN N/V over 1-2 minutes
Hydrocortisone 1% cream as directed for SQIG

○ Anaphylactic Kit:
Epipen 0.3mg 2pk auto injector as directed
Diphenhydramine 12.5 mg tab #4
Diphenhydramine 50 mg/ml vial #2 as directed

○ Skilled nursing as needed for teaching & administration

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment

Physician Signature **Date**