INTEGRATED CARE SYSTEMS

IMMUNE GLOBULIN
AUTO IMMUNE DISORDER
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

- ○ Acute Inflammatory Polyneuritis (Guillain-Barre Syndrome) ***G61.0***
- ○ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) ***G61.81***
- ○ Critical Illness Polyneuropathy (Acute Motor Neuropathy) ***G62.81***
- ○ Dermatomyositis, unspecified with respiratory involvement ***M33.91***
- ○ Dermatomyositis, unspecified with organ involvement ***M33.92***
- ○ Lambert-Eaton Syndrome, unspecified (excludes Neoplastic dz)) ***G70.80***
- ○ Multifocal Motor Neuropathy (MMN) ***G61.89 or G61.9***
- ○ Multiple Sclerosis (MS) ***G35***
- ○ Myasthenia Gravis with (acute) exacerbation ***G70.01***
- ○ Myasthenia Gravis without exacerbation ***G70.00***
- ○ Pemphigus Vulgaris ***L10.0***
- ○ Pemphigus Vegetans ***L10.1***
- ○ Pemphigus Foliaceous ***L10.2***
- ○ Brazilian Pemphigus ***L10.3***
- ○ Pemphigus Erythematosus ***L10.4***
- ○ Peripheral Neuropathy (Unspecified) ***G62.9***
- ○ Polymyositis with respiratory involvement ***M33.21***
- ○ Polymyositis with myopathy ***M33.22***
- ○ Polymyositis with other organ involvement ***M33.29***
- ○ Polymyositis organ involvement unspecified ***M33.20***
- ○ Stiff-Person Syndrome ***G25.82***
- ○ 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**