IVIG Referral Form

BIOHEALTH
INFUSION CENTER

www.biohealthic.com | info@biohealthic.com

PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

DOB: Patient Name: Patient Phone:

Patient Address: Patient Email:

NKDA Allergies: Weight (lbs/kg): Height:

ICD-10 code (required): ICD-10 description: Last Treatment Date: Last 4 SSN:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ Infusion to be administered per BioHealth protocols.

LABORATORY ORDERS

☐ CBC at each dose every ____________________

☐ CMP at each dose every ____________________

☐ CRP at each dose every ____________________

OTHER

PREMEDICATIONS

☐ acetaminophen (Tylenol) 500mg 650mg / 1000mg PO

☐ cetirizine (Zyrtec) 10mg PO

loratadine (Claritin) 10mg PO

diphenhydramine (Benadryl) 25mg 50mg PO IV

methylprednisolone (Solu-Medrol) 40mg 125mg IV

hydrocortisone (Solu-Cortef) 100mg IV

Other: ____

Dose: ____________________ Route: __________________

Frequency: ____

IVIG THERAPY ADMINISTRATION

Gammagard Privigen

Octagam Bivigam

Gamunex-C Asceniv

Dosing: ________g/kg or ________grams divided equally over ________ days every ________ weeks

Pre/Post Hydration Orders (optional)

REQUIRED DOCUMENTATION

Patient Demographics

Insurance Card/Information

Progress Notes Supporting DX

Medication List and H&P

Serum Creatinine *(within last 3 months if treatment naive)*

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions. **Order is valid for one year unless otherwise noted**

Provider Name (Print) **Provider Signature** **Date**

Have a Question? (786)460-6044

Fax Referral Form To: (786)219-3917

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