NORTHEAST REGIONAL
Infusion Services
AT
Richardson
MEDICAL CENTER
PHONE: (318) 728-8237 FAX: (877) 249-1191

☐ **STAT REFERRAL**

INTRAVENOUS IMMUNE GLOBULIN ORDER FORM

PATIENT INFORMATION

Last Name: ______________________ First Name: ______________________ MI____ DOB:____________

HT: __________ in WT: ________ ☐ lbs ☐ kg Sex: ☐ Male ☐ Female Allergies: ☐ NKDA, ______________________

____

Physician Name______________________ Contact Name ______________________ Contact Phone # ______________________

NPI #:______________________ Tax ID#:______________________ Fax #: ______________________

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: ICD 10 + Description:______________________ Date of Diagnosis:________________

PERTINENT MEDICAL HISTORY

Does patient have venous access? ☐ **YES** ☐ **NO** **If yes, what type** ☐ **MEDIPORT** ☐ **PIV** ☐ **PICC LINE** ☐ **OTHER:**______________________

PRESCRIPTION ORDERS:

a) ALL MEDIPORTS / IV ACCESSES WILL BE FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL POLICY
b) ALL PRODUCTS WILL BE PREPARED AND ADMINISTERED FOLLOWING HOSPITAL POLICY
c) 500 mL BAG OF 0.9% NS MAY BE HUNG AT KVO RATE

SELECT	DOSE	ROUTE	RATE	REPEAT EVERY	DURATION
☐	____________mg / kg	IV	TITRATE PER POLICY		
☐	Flat Dose:___________gm	IV	TITRATE PER POLICY		

PREMEDS

SELECT	MEDICATION	DOSE	ROUTE
☐	BENADRYL		
☐	ACETAMINOPHEN		
☐	SOLUMEDROL		
☐	FAMOTIDINE		
☐	Other:		

LABS

SELECT	LAB REQUESTED	WHEN	FREQUENCY
☐	BMP	☐ PRIOR ☐ POST	
☐	CMP	☐ PRIOR ☐ POST	
☐	BUN/CREATININE	☐ PRIOR ☐ POST	
☐	Other:	☐ PRIOR ☐ POST	
☐	Other:	☐ PRIOR ☐ POST	

NOTES/SPECIAL INSTRUCTIONS

Physician's Signature ______________________ **Time**______________ **Date**______________
**Signature Must Be Clear and Legible*

Cosignature (If Required)______________________ **Time**______________ **Date**______________
**Signature Must Be Clear and Legible*

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 1 (877) 249-1191.