FirstHealth OF THE CAROLINAS

7096.08.16145.01 Sunset Date: 6/2024

OP Intravenous Immune Globulin Infusion (IVIG) Referral

3POREF001

Place Patient Label Inside This Box

***** This section refers to the entire plan. If individual orders need a different interval, please indicate in each section below*****

Version 6/2021

Date of Infusion: _____

Patient Name: _____

Patient SSN (if available): _____

Insurance Name: _____

Secondary Insurance: _____

Diagnosis Code: _____

Diagnosis Code Description: _____

Lead Physician _____

Date of Birth: _____

Contact Number: _____

Policy Number: _____

Policy Number: _____

Precertification: ☐ Initiated ☐ Complete

Location to be Performed:

☐ Moore Regional Hospital (MRH)

☐ Montgomery Memorial Hospital (MMH)

Interval _____ Day _____ of every _____ month

Minimum Separation _____ days / weeks (circle one)

Next Due Date _____

Duration: ☐ Until discontinued ☐ ____ Treatments ☐ Until _____

Nursing Orders	Interval	Duration
☐ Vital Signs After start of infusion check vital signs every 30 minutes times 4, then with every Rate Change. Check vital signs for any change in patient's condition.	_____	_____
☐ Insert peripheral IV Once	_____	_____
Picc Access And Flush Orders		
☐ PICC Line Access Once	_____	_____
☐ Heparin, porcine (PF) 10 unit/mL injection 50 Units 50 Units, intravenous Once	_____	_____
Vascular Access Device (cvc) Access and Flush Orders		
☐ Central Venous Catheter (CVC) access Once	_____	_____
☐ Heparin, porcine (PF) injection 500 units, IV once	_____	_____
Pre-Medications		
☐ acetaminophen (TYLENOL) tablet 650 mg 650 mg, oral, For 1 Dose	_____	_____
☐ diphenhydrAMINE (BENADRYL) capsule 25 mg 25 mg, oral, For 1 Dose	_____	_____
☐ diphenhydrAMINE (BENADRYL) injection 25 mg 25 mg, intravenous, For 1 Dose	_____	_____

Provider Signature: _____ **Date:** _____ **Time:** _____

* May be used as EPIC Downtime Form

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Pre-Medications (continued)	Interval	Duration
☐ famotidine (PEPCID) tablet 20 mg 20 mg, oral, Once, For 1 Dose	_____	_____
☐ famotidine (PEPCID) injection 20 mg 20 mg, intravenous, For 1 Dose Dilute with 10 ml of NS and infuse over 2 minutes	_____	_____
☐ methylPREDNISolone sodium succinate PF (Solu-MEDROL) injection 125 mg 125 mg, intravenous, For 1 Dose	_____	_____
☐ Sodium chloride 0.9 % infusion 500 mL 500 mL, intravenous, at 10 mL/hr, Once Carrier Fluid	_____	_____
Medications		
☐ immune globulin (human) infusion intravenous, Once, For 1 Dose	_____	_____

Product specification:

Dose _____

- ☐ Gammagard S-D
- ☐ Gamunex-C
- ☐ Other_____
- ☐ No preference

Infusion Reaction Management		
☐ DiphenhydrAMINE (BENADRYL) injection 50 mg 50 mg, intravenous, Once as needed, itching, For 1 Dose	_____	_____
☐ acetaminophen (TYLENOL) tablet 650 mg 650 mg, oral, For 1 Dose	_____	_____
☐ EPINEPHrine (ADRENALIN) injection 0.3 mg 0.3 mg, subcutaneous, Once as needed, anaphylaxis, For 1 Dose	_____	_____

For Scheduling Fax Forms to: (910) 715-1177.

Provider Signature: _____ Date: _____ Time: _____

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