IMMUNOGLOBULIN ORDER FORM (IVIG/SCIG)

YOUR OSO REPRESENTATIVE: ______________________

DEMOGRAPHIC INFORMATION

Patient Name: ______________________ D.O.B: ______________
Address: ______________________
City: ______________ State: ________ Zip: ________ Phone: ____________
Primary Insurance Name: ______________________ ID#: ____________
Address: ______________________
City: ______________ State: ________ Zip: ________ Phone: ____________

CLINICAL INFORMATION

Patient Weight: ________ kg
Date Taken: ________
Allergies: ______________________

☐ No Known Allergies

☐ This is the patient's first time using Immunoglobulins
☐ Patient has been on Immunoglobulins
Date last infused: ____________
Immunoglobulin infused (include brand, dose, route and frequency):

Diagnosis: ______________________ **ICD-10:** ____________

PRESCRIPTION

☐ Intravenous Immunoglobulin
Nurse to place PIV prior to therapy
☐ Patient has IV access
Type of access: ______________________

☐ Subcutaneous Immunoglobulin

Immunoglobulin will be based on Oso availability
☐ *Do not substitute*
Preferred Immunoglobulin: ______________________
Reason: ______________________

Dose (grams): ________ Frequency: ______________ Duration: ____________

IVIG will be titrated at 30mL/hr x 30min, 60mL/hr x 30min, 90mL/hr x 30min, then 150mL/hr for the remainder of the infusion as tolerated.

Alternate titration: ______________________

Pre-medication:
Hydration Order (if any) to be administered IV over 250mL/hr to 500 mL/hr prior to IVIG infusion ____________
Acetaminophen 650mg PO 30 mins prior to infusion
Diphenhydramine 25mg PO 30 mins prior to infusion
Other: ______________________

Lab Order: ______________________ Frequency: ______________
In case of reaction: Follow Oso Protocol for anaphylaxis and infusion reactions ☐ SOLU-MEDROL 2 mg/kg IV

PHYSICIAN INFORMATION

MD Name: ______________________ Office Contact: ______________________
Address: ______________________
Phone: ______________________ Fax: ______________________
DEA#: ______________ License#: ______________ Medicaid#: ______________
MD Signature: ______________________ Date: ____________

Please fax the following information: History and Physical, Pertinent Lab Work, Front & Back Copy(s) of patient's insurance card(s)

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