Jean Walter Infusion Center - IVIG Therapy Order

www.JeanWalterInfusion.com
Phone: 443-354-3772 Fax:443-354-3767

Patient Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

Allergies : _____ Height & Weight: _____

Referring Provider: _____ NPI/DEA: _____

Specialty: _____

Please ensure all sections are completed. Incomplete forms will not be accepted.

CHECK ALL APPROROPRIATE CIRCLES THAT APPLY

IVIG:

- ◯ Gammagard (10%)
- ◯ Privigen (10%)
- ◯ Panzyga
- ◯ _____

Maintenance:

- ◯ _____ gm/kg daily over _____ days every _____ weeks
- ◯ Infuse dose over _____ hours or per manufacturer guidelines
- ◯ Other: _____

THESE MEDICAIONS ARE INTERAVENOUS

PLEASE NOTE:

*If bottle size does not accommodate total grams we will increase to next bottle size available unless indicated otherwise check circle to decrease gram total: ◯

PICC/ Port Line: Yes or No

Diagnosis W/ ICD 10: _____

Frequency: _____

Maintenance: _____

Number of Refills: _____

Please indicate here if additional labs are required at time of infusion:

_____

Please indicate if any premedication is required: ◯ CHECK HERE IF NO PREMEDICATION(S) REQUIRED

- ◯ Acetaminophen: _____ mg
- ◯ Solumedrol: _____ mg
- ◯ Diphenhydramine: _____ mg
- ◯ Other: _____ mg

IF NO PREMEDICATIONS or ROUTE INDICATED ABOVE, WE WILL USE FDA RECOMMENDATIONS

SCRIPTS ARE ONLY VALID FOR 6 MONTHS

Provider Signature: _____ **Date: _____**