Infusion for Health
77 Rolling Oaks Drive, Suite 201
Thousand Oaks, CA 91361
Phone: 805-719-3700 Fax: 805-852-2636

IVIG INFUSION ORDER (GAMMAGARD)

Please fax a copy of patient's demographics, insurance information, current lab results, H&P relevant to the diagnosis & current medications.

Date: ____/____/____

Patient Name: ____ **DOB:** ____/____/____

Allergies: ______________________________________ **Wt:** ______ **lbs / kg Ht:**__________

Diagnosis: ______________________________ **ICD-10:** ___________________________

PRE-MEDICATIONS:

Benadryl	☐ **PO**	☐ **IV**	☐ **25mg** ☐ **50mg**	☐ **Pre med**	☐ **PRN**
Acetaminophen	☐ **PO**		☐ **650mg**	☐ **Pre med**	☐ **PRN**
Zyrtec	☐ **PO**		☐ **10mg**	☐ **Pre med**	☐ **PRN**
Solu-Medrol		☐ **IV**	______**mg**	☐ **Pre med**	☐ **PRN**
Normal saline		☐	_______ **mL**		☐ **PRN**

IVIG (GAMMAGARD) IV Dosage:

10% Immunoglobulin solution (____________gm/kg): = _____________gm

Frequency: ____________________________ **Duration:** ____________________

Start Date of Infusion: _____/_____/_____

Printed Provider's Name: ____ **NPI:** ___________________

Provider's Signature: ____ **Date:**_____/_____/_____

Office phone number: _____________________________ **Office Fax:**_____________________________

Office address: ____ **Contact person:** _________________

Revised 10/17/17