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

IVIG INFUSION ORDER
(GAMUNEX-C)

Please fax a copy of patient's demographics, insurance information, current lab results, H&P relevant to the diagnosis & Rx, and 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 (GAMUNEX-C) 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 9/26/17