Phone: (805) 719-3700
Fax: (805) 413- 9099
Website: infusionforhealth.com

IVIG INFUSION ORDER
(GAMUNEX-C)

Please fax a copy of patient's:

- □ **Demographics**
- □ **Current Lab Results**
- □ **Medication List**
- □ **Copy of Insurance Cards**
- □ **H & P Relevant to the Diagnosis**

Date: ____/____/____

Patient Name: _____ DOB: ____/____/____

Allergies: _____ Wt: _____ lbs / kg Ht:_____

Diagnosis: _____ICD-10: _____

PRE-MEDICATIONS:	**Benadryl**	☐ **25 mg** ☐ **50 mg**	☐ **PO**	☐ **IV**	☐ **Pre-med**	☐ **PRN**
	Tylenol	☐ **650 mg**	☐ **PO**		☐ **Pre-med**	☐ **PRN**
	Zyrtec	☐ **10 mg**	☐ **PO**		☐ **Pre-med**	☐ **PRN**
	Solu-Medrol	**_____ mg**	☐ **IV**		☐ **Pre-med**	☐ **PRN**
	Normal Saline	**_____ mL**	☐ **IV**			☐ **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: _____