IVIG Infusion Order
(Gamunex-C)

INFUSION FOR HEALTH

Ph: 805-719-3700 | Fax: 805-852-2636

Date: ____ / ____ / ____ Treatment Location: _____

***Please fax a copy of the following patient information:** ☐ Demographics ☐ Insurance Information ☐ Current Lab Results ☐ H & P Relevant to the Diagnosis ☐ Current Medications

PATIENT INFORMATION

Patient Name: _____

DOB: ____ / ____ / ____

Allergies: _____

Weight: _____ lbs / kg Height: _____

Diagnosis: _____

ICD-10: _____

PROVIDER INFORMATION

Printed Provider's Name: _____

Signature: _____

NPI: _____ Date: ____ / ____ / ____

Phone: (____) ____ - ____ Fax: (____) ____ - ____

Office Address: _____

Contact Person: _____

PRE-MEDICATIONS:

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

IVIG (GAMUNEX-C) IV DOSAGE:

10% Immunoglobin solution (_____ gm/kg): = _____ gm

Frequency: _____ Duration: _____

Start Date of Infusion: ____ / ____ / ____

Revised 12/01/20