IVIG Infusion Order

(Gammagard)

InfusionForHealth.com
Ph: 888-777-1945 | Fax: 805-852-2636

Date: ______________________ Treatment Location: ______________________

***Please fax a copy of the following patient information:**

☐ Demographics ☐ Insurance Information ☐ Current CBC & CMP
☐ 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: ______________________

Contact Email: ______________________

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:		☐ IV	☐ ______ mL			☐ PRN

IVIG (GAMMAGARD) IV DOSAGE:

Date of Last Treatment, If Continuation:

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

Frequency: ______________________ Duration: ______________________

Start Date of Infusion: ______________________

Revised 09/06/22