

IVIg Infusion Order

(Gamunex-C)



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 (GAMUNEX-C) IV DOSAGE:

Date of Last Treatment, If Continuation: _____

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

Frequency: _____ Duration: _____

Start Date of Infusion: _____