

Phone: (888) 571-3100 • Fax: (800) 582-9315

Date: _____

Demographics

Patient Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Date of Birth: _____ Sex: Male Female
 Phone: (h) _____ (w) _____
 (c) _____ SS#: _____
 HT: _____ WT: _____ Next of Kin: _____

Insurance Information:

Primary Insurance: _____
 Member ID #: _____ Group #: _____
 Policy Holder: _____ Relationship: _____
 Secondary Insurance: _____
 Member ID #: _____ Group #: _____
 Policy Holder: _____ Relationship: _____

Physician Orders: (Please check the following)

IVIG Dose _____ grams/ kg / day X _____ days
or _____ grams X _____ days.
 Interval (frequency of therapy) _____
 # of refills _____

Benadryl 25 - 50 mg PO _____
 Benadryl 25 - 50 mg IV _____
 Tylenol 650 or 1000 mg PO _____
 IV Steroids: _____ Dose: _____ Pre/Post
 IV Hydration: _____ Pre/Post
 Anaphylaxis Kit per protocol
 Saline 5 - 10 ml pre/post infusion and PRN
 Heparin 100 u/ml 5ml post infusion and PRN
 Skilled Nursing visits as required
 Standard supplies as needed
 First dose to be given in home
 Has the patient received IVIG previously? Yes No
 Date of last dose: _____ Allergies: _____
 Anticipated Start Date: _____

Diagnosis: (Please check one of the following)

357.81 Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
 333.91 Stiff Person Syndrome
 358.0 Myasthenia Gravis
 340.0 Multiple Sclerosis relapsing/remitting
 356.4 Polyneuropathy Idiopathic, Progressive
 357.0 Guillian-Barre Syndrome
 710.4 Polymyositis
 710.3 Dermatomyositis
 356.4 Multifocal Motor Neuropathy
 279.06 Common Variable Immune Deficiency (CVID)
 IgG Level: _____ Date: _____
 279.00 Hypogammaglobulinemia
 IgG Level: _____ Date: _____
 287.3 Thrombocytopenia (ITP)
 Plt Count: _____ Date: _____
 Other: _____
 ICD-9 Code: _____

Prescribing Physician:

Name: _____
 Address (please include facility name):

 Phone: _____ Fax: _____
 Specialty: _____
 License #: _____ UPIN #: _____
 DEA #: _____ NPI #: _____
 Physician Signature: _____
 Date: _____