SEMINOLE HOSPITAL DISTRICT
INFUSION CENTER
Phone: 432-758-4716 Fax: 877-249-1191

☐ **STAT REFERRAL**

INTRAVENOUS IMMUNOGLOBULIN ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI_____ DOB:_____

HT: _____ in WT: _____ kg Birth Sex :( ) Male ( ) Female Allergies: ( ) NKDA, (Or):_____

_____

Provider Name_____ Contact Name _____ Contact Phone # _____

NPI #:_____ Tax ID #:_____ Fax #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: ICD 10 + Description:_____ Date of Diagnosis:_____

PERTINENT MEDICAL HISTORY

Does patient have venous access? ☐ **YES** ☐ **NO** **If yes, what type** ☐ **MEDIPORT** ☐ **PIV** ☐ **PICC LINE** ☐ **OTHER:**_____

PRESCRIPTION ORDERS:

a) ALL MEDIPORTS / IV ACCESSES WILL BE FLUSHED WITH SALINE PER HOSPITAL PROTOCOL PRN UNLESS OTHERWISE NOTED BY PROVIDER

b) ALL PRODUCTS WILL BE PREPARED AND ADMINISTERED PER STANDARD PHARMACY CONCENTRATIONS AND HOSPITAL POLICY

c) DOSES MAY BE ROUNDED TO NEAREST VIAL WITHIN 10 GRAM(S) OF THE PRESCRIBED DOSE PER HOSPITAL PROTOCOL UTILIZING IDEAL BODY WEIGHT UNLESS ACTUAL BODY WEIGHT IS LESS

d) SUBSTITION MAY BE PERMITTED BASED ON AVAILABILITY. IF ALTERNATIVE PRODUCT REQUESTED/SUBSTITUTED.

PREFERRED BRAND NAME:_____

SELECT	DOSE	ROUTE	RATE	REPEAT EVERY	DURATION
	g / kg	**IV**			
	Flat Dose: g	**IV**			

PREMEDS

SELECT	MEDICATION	DOSE	ROUTE
	BENADRYL		
	ACETAMINOPHEN		
	SOLUMEDROL		
	FAMOTIDINE		
	Other:		

LABS

SELECT	LAB REQUESTED	WHEN	FREQUENCY
	BMP	**( ) PRIOR ( ) POST**	
	CMP	**( ) PRIOR ( ) POST**	
	BUN/CREATININE	**( ) PRIOR ( ) POST**	
	Other:	**( ) PRIOR ( ) POST**	
	Other:	**( ) PRIOR ( ) POST**	

NOTES/SPECIAL INSTRUCTIONS

Physician's Signature _____ **Time**_____ **Date**_____
**Signature Must Be Clear and Legible*

Cosignature (If Required)_____ **Time**_____ **Date**_____
**Signature Must Be Clear and Legible*

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 1 (877) 249-1191.