IV Immunoglobulin Order Form

Select referral location:

Akron
Athens
Cincinnati (Blue Ash)
Cincinnati (West)
Cleveland
Columbus (East Broad)
Columbus (Hilliard)
Columbus (Worthington)
Dayton (Beavercreek)
Dayton (Englewood)
Findlay
Liberty
Mansfield
Perrysburg
Springfield
Toledo
Crestview Hills (NKY)

For new referrals, please include recent labs and last two office visit notes.

Fax completed form to 888-977-0914

Phone: 877-787-8720 • www.horizoninfusions.com

1. PATIENT INFORMATION

Name: | DOB:

Phone: | Other Phone:

Email:

Social Security #: | Allergies:

Gender: M F | Weight: Lbs Kg

Patient Status: New to therapy Continuing therapy Next due date *(if applicable)*:

2. INSURANCE INFORMATION *(required)*

Please submit copies of the front and back of primary and/or secondary insurance cards with this referral.

3. PHYSICIAN INFORMATION

Physician Name: | NPI#:

License #: | TIN#: | DEA#:

Address:

City: | State Zip

Office Contact: | Email:

Office phone: | Office fax:

4 . DIAGNOSIS INFORMATION *(and year of diagnosis)*

CVID (_______) Dermatomyositis (_______) ICD 10

PI (_______) Other: _____________

5. PRESCRIPTION INFORMATION *(requires new order every 12-months)*

Immune Globulin ___________________________________

Administer _____ GMS at

______ gm/kg

OR

______ mg/kg every _______ weeks

Concentration _____ %

Infusion Rate: Start _____ ml/hr

Max: _____ ml/hr

Ramp Up: Every _____ min by _____ ml/hr

Hydration (normal saline):

N/A Pre IG ______ ml Post IG ______ ml

Vital signs per HI protocol

Anaphylaxis & Hydration Management per HI protocol

PRE-MEDICATIONS N/A

Acetaminophen 500mg 650mg 1000mg

Fexofenadine (Allegra) 180mg PO (or other non-sedating antihistamine)

Diphenhydrimine (Benadryl) 25mg 50mg PO IV (requires driver)

Methylprednisolone (Solu-Medrol) 40mg 80mg 125mg IV

Prednisone ___________ mg PO

Other ________________________________

POST-MEDICATIONS N/A

Acetaminophen 500mg 650mg 1000mg

Prednisone __________ mg PO

Other ________________________________

6. LABS

CBC w/Diff Each Infusion Other Frequency (*specify*): ______________________________

CRP Each Infusion Other Frequency (*specify*): ______________________________

CMP Each Infusion Other Frequency (*specify*): ______________________________

ESR Each Infusion Other Frequency (*specify*): ______________________________

Hepatic Panel Each Infusion Other Frequency (*specify*): ______________________________

Renal Panel Each Infusion Other Frequency (*specify*): ______________________________

Quantiferon TB Gold, annually, last completed *(date)*: ____

Other *(specify)*: ____

7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE DATE