Infusion

IVIG

Salem Health® Hospitals & Clinics

PATIENT INFORMATION

Last Name: _____ **First Name:** _____ **MI:** _____ **DOB:** _____

Address: _____ City: _____ Zip Code: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

ORDERING PROVIDER INFORMATION

Referring Provider: _____ Date of Referral: _____ NPI: _____

Phone Number: _____ Fax Number: _____

INSURANCE INFORMATION

The following information is required to obtain insurance authorization. Information not provided will cause a delay in treatment. ☐ Patient is uninsured.

1. Copy of current insurance card. 2. Copy of demographics sheet 3. Copy of most recent OV note and labs

PRIMARY DX: THE MAIN DIAGNOSIS FOR ORDERED TREATMENT

Provide ICD-10 code and description: _____

Weight: _____ Height: _____ Allergies: _____

Is the patient ambulatory? ☐ Yes ☐ No Is the patient in a SNF? ☐ Yes ☐ No

Has the patient previously recieved IVIG? ☐ No ☐ Yes: What Brand?

Has the patient had an adverse reaction during previous administrations of IVIG? ☐ No ☐ Yes:

Please explain: _____

ORDER INSTRUCTION

☐ Formulary IVIG: **OR** Non-formulary IVIG: specify Brand and reason

Dose: _____ Grams per day X _____ days

☐ One time dose **OR** ☐ Repeat every _____weeks for _____Cycles

Other Dosing: _____

Pharmacy and nursing may divide daily vial size in any combination to achieve total ordered Gram dose.

Pharmacy to round to the nearest 5 gm increment and use hospital formulary unless otherwise ordered above

Pt should be instructed to take oral premeds at home*

PRE-MEDICATIONS: (if patient did not already take at home)

☐ Acetaminophen 650mg P.O. PRN every 4 hrs

☐ Diphenhydramine 25mg IV

☐ Famotidine 40mg IV

☐ Dexamethasone 20mg IV

ADDITIONAL MEDICATIONS/ORDERS & INSTRUCTIONS:

☐ *(other)* _____

☐ *(other)* _____

☐ *(other)* _____

☐ *(other)* _____

LABORATORY TESTING: ☐ No labs

☐ CBC/diff: Frequency: _____ ☐ IgG: Frequency _____ ☐ _____

☐ CMP: Frequency: _____ ☐ _____ ☐ _____

FOR PATIENTS WITH CENTRAL IV ACCESS (PICC OR PORT)

☒ CVAD care per Salem Health CVAD Access Policy. *(Lippincott)* Follow routine CVAD catheter care per manufacture device maintenance card if card is available.

☒ Cathflo per Salem Health Central Venous Access Device declotting *(Lippincott)*

☒ 1 View Chest X-ray to verify catheter tip location PRN for the following, *(notify physician or provider)*: catheter migration greater than 5 cm, s/sx of tip malposition *(occlusion unresolved with Cathflow, discomfort in the arm, neck, or chest.)* Unusual sensations or sounds when the catheter is flushed, neck vein engorgement or heart palpitations.

Provider Signature _____ Provider Printed Name _____ Date: _____