

IVIG INFUSION ORDER (Gamunex-C)



INFUSIONMED | USA
LIVING YOUR BEST LIFE. ONE DROP AT A TIME.

Date: ___/___/___

PATIENT INFORMATION

Patient Name: _____ DOB: ___/___/___ Phone: _____

Height: _____ Weight _____ lbs / kg

Allergies: _____

Diagnosis: _____ ICD-10: _____

Labs to be drawn by: Infusion Clinic Referring Physician

Lab Orders: _____

PRE-MEDICATIONS

Benadryl:	<input type="radio"/> PO	<input type="radio"/> IV	<input type="radio"/> 25mg	<input type="radio"/> 50mg	<input type="radio"/> PreMed	<input type="radio"/> PRN
Acetaminophen:	<input type="radio"/> PO		<input type="radio"/> 650mg		<input type="radio"/> PreMed	<input type="radio"/> PRN
Zyrtec:	<input type="radio"/> PO		<input type="radio"/> 10mg		<input type="radio"/> PreMed	<input type="radio"/> PRN
Solu-Medrol:		<input type="radio"/> IV	<input type="radio"/> ___mg		<input type="radio"/> PreMed	<input type="radio"/> PRN

IVIG (GAMUNEX-C) ORDERS

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

Dose: _____ (10mg/kg) Infusion Start Date: ___/___/___

Frequency: _____ Duration: _____

PROVIDER INFORMATION

Provider's Name: _____ Signature: _____

Phone: _____ Fax: _____ Date: ___/___/___

Office Address: _____

Email Address: _____ Contact Person: _____

PLEASE SEND COPY (FRONT AND BACK) OF INSURANCE CARD

PHONE: 972-810-0990

FAX: 972-810-0994