Horizon Infusions

# IV Immunoglobulin

**Select referral location:**

- ☐ Akron
- ☐ Athens
- ☐ Canton
- ☐ 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)
- ☐ Warren

**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 (ICD 10 Code *Required*)

☐ CVID (_____)
☐ PI (_____)
☐ Dermatomyositis (_____)
☐ 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