Infusion Associates
3230 Eagle Park NE, Suite 101
Grand Rapids, MI 49525
Phone: 616-954-0600 Fax: 616-954-1675

IVIG INFUSION ORDERS

***Please fax a copy of patient's Demographics, Insurance information, Current Lab Results, H&P, and Current Medications*

Date: _____/_____/_____

Patient Name: _____ **DOB**: _____/_____/_____

Allergies: _____ **Patient Weight:** _____lbs / kg **Height:**_____

DX CODES: ***ICD-10*** : _____, _____, _____

LABS to be drawn: ☐ _____ Frequency:_____
☐ **NONE**

Intravenous Immune Globulin:

10 % Immunoglobulin solution (_____gm/kg): =_____gm

Frequency:_____Duration:_____

Start Date of Infusion: _____/_____/_____ **End Date of Infusion**: _____/_____/_____

Infuse per Infusion Associates IVIG infusion protocol

Pre- Medications:

Benadryl PO or IV	25mg or 50mg	☐Yes ☐ No
Tylenol PO	650mg x1	☐Yes ☐ No
Zyrtec PO	10mg x1	☐Yes ☐ No

Other: _____

Rx Expiration Date: _____/_____/_____

Printed Provider's Name: _____

Provider's Signature: _____

Office Phone Number: _____ **Fax Number:** _____