3-Hole 1/4 1 3/8 c-to-c

IVIG ORDER SHEET

Orders Provider

Please mark appropriate boxes, No Orders Will Be Activated If Not Clearly Indicated

Diagnosis: _____

Allergies: _____

***Ht** _____ **inches**
***Wt** _____ **lbs**
***M²** _____

Laboratory Studies:

- ❑ **CBC-D** **monthly or every** _____
- ❑ **BMP / CMP** **monthly or every** _____
- ❑ **IgG Level** **monthly or every** _____
- ❑ **PT/INT** **monthly or every** _____
  Diagnosis for PT/INR _____
- ❑ _____ **monthly or every** _____

Pre-Medication Orders: **Circle Dosage & Route of Administration**

❑ Acetaminophen [TYLENOL]	650 mg	1000 mg	P.O.
❑ Diphenhydramine [BENADRYL]	25 mg	50 mg	P.O. **or** IV **(either unless specified)**
❑ Methylprednisolone [SOLU-MEDROL]	75 mg	125 mg	IVP
❑ Cimetidine [TAGAMET]	200 mg	400 mg	P.O.
❑ Fexofenadine [ALLEGRA]	60 mg	180 mg	P.O.

Note: Do not give Fexofenadine [ALLEGRA] if patient is pregnant and less than 12 weeks gestation

❑ Aspirin (enteric)	81 mg	325 mg	650 mg	P.O.

- ❑ Prehydrate with 500 mls of NSS over 30 minutes if not contraindicated (Renal failure or CHF)
- ❑ Hydrate with (circle one) **500** mls or **1000** mls of NS concurrent with IVIG administration
- ❑ Other Pre-Med Orders: _____

IVIG Requested: ❑ No Manufacturer Specified

❑ Gamunex (10% solutions) ❑ Flebogamma ❑ Other: _____

IVIG ORDER: Dose: _____ gms Total/Month: _____ gms

Frequency:

- ❑ daily for _____ days
- ❑ weekly
- ❑ 1 dose / month
- ❑ 2 doses / month
- ❑ 2 times a week every other week
- ❑ other: _____

Administration:

❑ Standard Titration Procedure **or** ❑ Adjustment to current titration procedure: _____

Required Entry: (√ One): ❑ **Call me for Reaction OR** ❑ **Infusion Center Physician manages reaction**

Physician Phone Number: _____ **(to contact ordering MD for Reactions)**

Signature: _____
Printed Name/ID#: _____
Date: _____ Time: _____

Renewals or changes:

_____ Signature: _____ Date: _____ Time: _____
_____ Signature: _____ Date: _____ Time: _____
_____ Signature: _____ Date: _____ Time: _____
_____ Signature: _____ Date: _____ Time: _____

PATIENT IDENTIFICATION

PRESBYTERIAN
Presbyterian Infusion Center
Tele: (505) 563-1309
Fax: (505) 224-7156