vitalcare of CENTRAL MISSISSIPPI

Fountains Infusion Center

159 Fountains Blvd. Madison, MS 39110
Phone: 601.859.8200 Fax: 601.859.8201

IVIG
INFUSION ORDERS

****REQUIRED INFORMATION****

☐ This signed order form from the provider
☐ Patient demographics & insurance information
☐ **Clinical/Progress Notes, Labs & Tests** supporting primary diagnosis (ICD-10 below)

Patient Name:	**DOB:**
Allergies:	**Patient Phone:**

Diagnosis:

☐ _____ ☐ (ICD-10: _____)

Pt. Weight _____ kg Allergies:_____

IVIG ORDERS

☐ **Pharmacist to identify clinically appropriate brand/infusion rates. May substitute based on product availability.**

☐ **Do not substitute. Administer brand:** _____

- *Infuse entire contents of Ig infusion bag/vial(s) per current dose.*
- *If needed, round dose to nearest whole 5 gm vial for IV doses.*

Loading Dose: _____ ☐ mg/kg IV x _____ day(s) or divided over _____day(s)
☐ grams/kg
☐ grams

Maintenance Dose:_____ ☐ mg/kg IV x _____ day(s) divided over _____day(s)
☐ grams/kg
☐ grams

Frequency: Every_____weeks or ☐ _____one time dose **Refills:**_____

Protocol Pre-Medication Orders: Tylenol 650mg PO, *please choose one antihistamine:*

☐ Cetirizine 10mg PO
☐ Diphenhydramine 25mg PO
☐ Loratadine 10mg PO

Additional Pre-Medication Orders:

☐ Solu-Medrol _____ mg IVP
☐ NS 0.9% _____ mL IV
☐ Zofran 4mg IV
☐ Other_____

Additional Instructions/Labs:

Physician Name:	**Phone:**	**Fax:**
****Physician Signature:**	**Date:**	