Clearwell Infusion Centers

Phone: (305)306-7147
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Email: intake@clearwellinfusion.com

OCTAGAM-10 (Immune globulin intravenous)

PATIENT DEMOGRAPHICS

Patient Name: _____
Date of Birth: _____ M: ☐ F: ☐ Address: _____
Phone: _____ City, State, Zip: _____
Email: _____

Allergies:

PRIMARY DIAGNOSIS

ICD-10 Code:

DOCUMENTATION (PLEASE ATTACH)

Clinical / Progress Notes, Labs, Tests supporting primary diagnosis

☐ IgG level every 3 months, CMP every 6 months

Clearwell Infusion Centers will draw maintenance labs unless otherwise directed by Referring Provider

PRE-MEDICATION

☐ Acetaminophen 1000mg PO
☐ Diphenhydramine 25mg PO
☐ Ceterizine 10mg PO
☐ Loratadine 10mg PO
☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
☐ Other:

PRIMARY MEDICATION ORDER

Dosage (Use IBD unless ABW < IBW)

☐ _____ gm/kg
Total dose: _____ gm (round to nearest 5 mg)
☐ Infuse over _____ days

Frequency

☐ Every _____ for _____

Patient Weight:

_____ lbs
_____ kg

NOTES

ORDERING PROVIDER

Provider Name: _____ NPI: _____
Practice Name: _____ Phone: _____
Office Contact: _____ Fax: _____
Practice Address: _____
City, State, Zip: _____

Provider Signature: _____ Date: _____