Phone: (305) 306-7147 | Fax: (305) 402-9559 | Email: contact@clearwellinfusion.com

Clearwell
Infusion Centers

IVIG (intravenous immunoglobulin)

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
☐ CBC, CMP within 3 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
☐ Diphenhydramine 25 mg PO
☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
☐ Other:

PRIMARY MEDICATION ORDER

Brand

☐ Gamunex (10%)
☐ Gammagard (10%)
☐ Gammaplex (10%)
☐ Privigen (10%)
☐ Flebogamma DIF (10%)
☐ Carimune _____ %
☐ Octagram (10%)
☐ Gammaked (10%)

Dosage

☐ gm per day x _____ days
☐ mg/kg over

Patient Weight:

_____ lbs
_____ kg

Frequency

☐ one-time dose/treament
☐ every _____ weeks

NOTES

_____

ORDERING PROVIDER

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

Provider Signature: _____ Date: _____