Immunoglobulin—Immune Deficiency Referral Form

Phone 405.548.4848 **Toll Free** 888.848.4588 **Fax** 405.418.4442

PATIENT INFORMATION

Patient Name: Date of Referral:
Address: SSN: Gender:
City, State, Zip: DOB: Age:
Caregiver Name (if other): Relationship: Phone:
Emergency Contact: Relationship: Phone:
Primary Insurance Subscriber: Primary Language:
Policy #: Group #: Phone #:
Insurance Phone: Work Phone #:

PRIMARY DIAGNOSIS

☐ D80.0 Hereditary hypogammaglobulinemia
☐ D80.1 Nonfamilial hypogammaglobulinemia
☐ D80.2 Selective deficiency of immunoglobulin A
☐ D80.7 Transient hypogammaglobulinemia of infancy
☐ D80.9 Immunodeficiency with predominantly antibody defects, unspecified
☐ D81.0 Severe combined immunodeficiency
☐ D83.0 Common Variable Immune Deficiency
☐ D84.9 Immunodeficiency
☐ Other - Please indicate ICD10-CM code & description:____________________________

Date of diagnosis or years with disease:____________________________

MEDICAL HISTORY

Allergies: ☐ NKDA
☐ Yes, listed:____________________________

Ht:__________________ ☐ in ☐ cm
Wt:__________________ ☐ lbs ☐ kg
Date Taken:____________________________

Other Medical History:
☐ Cardiac Disease ☐ Diabetic
☐ Renal Dysfunction
☐ Migraine
☐ Other:____________________________

Access: ☐ Peripheral ☐ SQ
☐ **Port** ☐ ____________________________

PRESCRIPTIONS & ORDERS

Is this the first dose? ☐ Yes ☐ No
If no, first dose given?____________________________
☐ Start ASAP
☐ First/next dose due? ____________________________
Administer: ☐ Intravenous ☐ Subcutaneously
Product: ☐ Pharmacist to determine
OR ☐ ____________________________
Dose:
☐ _________ mg/kg every _________ week(s) for _________ cycle(s)
☐ _________ grams every _________ week(s) for _________ cycle(s)
☐ Other:____________________________

Please attach and fax
1. Insurance card(s) and demographic information
2. Recent clinical assessment note or H&P
3. Current medication list

OTHER ORDERS

Premedication:
☐ Diphenhydramine (Benadryl®) ☐ 25mg or ☐ 50mg orally 30 mins before infusion
☐ Acetaminophen (Tylenol®) ☐ 500mg or ☐ 1000mg orally 15-30 mins before infusion
☐ Heparin 5000 units subcutaneously pre & post IG infusion
☐ None
☐ Other:____________________________

Lab Orders:
☐ IgG Levels
☐ BUN and Serum Creatinine
☐ Prior to first infusion
☐ After _________ infusion(s)
☐ Other:____________________________

☐ Immunofixation Immunoglobulins Quantitation
☐ Prior to first infusion
☐ After _________ infusion(s)

Adverse and Anaphylactic Reactions will be treated per OptionOne protocol.

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.	**Signature:**____________________ **Date:**____________________

PHYSICIAN INFORMATION

Name: Hospital/Clinic:
Address: Office Contact:
City, State, Zip: Phone: Fax:
NPI: UPIN: License #: