Immunoglobulin—Neurological Disorder 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

- ☐ G61.81 - Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
- ☐ G61.0 - Guillian-Barré Syndrome
- ☐ G60.9 - Peripheral Neuropathy, Unspecified
- ☐ G35 - Multiple Sclerosis
- ☐ G72.41 - Inclusion Body Myositis
- ☐ G25.82 - Stiff-Person Syndrome
- ☐ G73.3 - Lambert-Eaton Myasthenic Syndrome
- ☐ G70.00 - Myasthenia Gravis
- ☐ M33.20 - Polymyositis
- ☐ M33.90 - Dermatomyositis Unspecified
- ☐ M33.00 - Dermatomyositis Juvenile Unspecified
- ☐ Other - Please indicate ICD10-CM code & description:_____

MEDICAL HISTORY

Allergies: ☐ NKDA

☐ Yes, listed:_____

Ht:_____ ☐ in ☐ cm

Wt:_____ ☐ lbs ☐ kg

Date Taken:_____

Other Medical History:

- ☐ Cardiac Disease
- ☐ Diabetic
- ☐ Renal Dysfunction
- ☐ Migraine
- ☐ Other:_____

Please attach and fax

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

PRESCRIPTIONS & ORDERS

Is this the first dose?

☐ Yes ☐ No

If no, first dose given?_____

☐ Start ASAP

☐ First/next dose due? _____

Administer IG: Route of Administration:

☐ Intravenous ☐ Subcutaneously

- ☐ _____ grams/kg over _____ day(s), repeat course every _____ week(s) for _____ cycle(s)
- ☐ _____ mg/kg or _____ grams every _____ week(s) for _____ time(s)
- ☐ 400 mg/kg daily for _____ day(s), repeat course every _____ week(s) for _____ cycle(s)
- ☐ Other Regimen:_____

OTHER ORDERS

Premedication:

- ☐ Pre-hydration: ☐ NS 250mL ☐ NS 500mL
- ☐ Diphenhydramine ☐ 25mg or ☐ 50mg orally before infusion
- ☐ Acetaminophen ☐ 500mg or ☐ 1000mg orally before infusion
- ☐ Heparin 5000 units subcutaneously pre & post IG infusion
- ☐ Hydrocortisone 100mg IV
- ☐ Other:_____

Access: ☐ Peripheral ☐ Port ☐ SQ ☐ Other:_____

Lab Orders:

- ☐ BUN and Serum Creatinine drawn
- ☐ Every Infusion
- ☐ Every Other Infusion
- ☐ Other:_____

Adverse and Anaphylactic Reactions will be treated per OptionOne protocol.

Special Instructions:_____

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 #:	