FAMILY PHARMACY VITAL CARE
1720 Hillcrest Drive
Vernon, TX 76384
Phone: 940-552-2999
Fax: 940-552-5347

VITAL CARE® Home Infusion Services

IMMUNE GLOBULIN REFERRAL FORM

Date: _____

Demographics

Patient Name: _____
Address: _____
City: _____ State: _____ Zip: _____
DOB: ___/___/___/ ☐ Male ☐ Female
Phone: _____ 2nd Phone: _____
SSN: _____ Ht: _____ Wt: _____

Insurance Information *(Attach copy of card, if available)*

Primary Insurance
Member#: _____ Group #: _____
Policy Holder: _____ Relation: _____

Secondary Insurance
Member #: _____ Group #: _____
Policy Holder: _____ Relation: _____

Physician's Orders *(Please check the following)*

☐ Ig Therapy Dose _____ grams/kg/day x _____ days
or _____ grams/day x _____ days

Interval (*freq. of therapy*): _____ # of refills: _____

Ig Product: _____ ☐ Don't Substitute

Route of Admission: ☐ IV ☐ SC ☐ IM

Access Device: ☐ Peripheral Catheter ☐ Other: _____

Additional medications to be maintained at infusion site and administered as necessary:

☐ Epinephrine: 1:1000 Select dose
_____0.3mg _____0.4mg _____0.5mg

☐ Benadryl 50mg x 1 for itching, rash, redness
_____PO _____IM _____IV x 2-3 min push

☐ Provide anaphylactic kit, as indicated.

☐ Flush Orders: Normal Saline 10ml flush per SASH Method
Heparin 10 u/ml 5 ml flush per SASH Method (when indicated)

☐ Skilled nursing visits as required

☐ Standard supplies as needed.

☐ Additional Orders/Info: (including lab orders, pre-meds, vascular device, supplies, anaphylaxis orders, and nursing):

_____

Diagnosis

☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
☐ Myasthenia Gravis **without acute exac.**
☐ Myasthenia Gravis **with acute exac.**
☐ Multiple Sclerosis
☐ Polyneuropathy Idiopathic, **Progressive**
☐ Guillian-Barre Syndrome (acute infective polyneuritis)
☐ Multifocal Motor Neuropathy
☐ Common Variable Immune Deficiency (CVID)
IgG Level: _____ Date: _____
☐ Hypogammaglobulinemia
IgG Level: _____ Date: _____
☐ Congenital Hypogammaglobulinemia
☐ Immunodeficiency with increased IgM
☐ Wiskott-Aldrich Syndrome
☐ Combined Immunity Deficiency
☐ Other: _____
ICD-10 Code, if applicable: _____

Prescribing Physician

Name: _____

Address: (please include facility name)

Phone: _____ Fax: _____

Specialty: _____

License#: _____ UPIN#: _____

DEA: _____ NPI: _____

Signature: _____

Date: _____

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