



IV Immunoglobulin Order Form

Please select which location you are referring this patient to: ☐ Blue Ash ☐ Worthington ☐ Crestview Hills
Please fax completed form to 888-977-0914. For new referrals, please include recent labs and last two office visit notes.

Toll Free Phone: 877-787-8720 • www.horizoninfusions.com

1. PATIENT INFORMATION

Name:	DOB:
Home phone:	Other phone:
Email:	
Social Security #:	Allergies:
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Weight: <input type="checkbox"/> Lbs <input type="checkbox"/> Kg
Patient Status: <input type="checkbox"/> New to therapy <input type="checkbox"/> Continuing therapy <input type="checkbox"/> Next due date (if applicable):	

2. PHYSICIAN INFORMATION

Physician's name:		NPI#:
License #:	TIN#:	DEA#:
Address:		
City:	State:	Zip:
Office contact:	Email:	
Office phone:	Office fax:	

3. DIAGNOSIS INFORMATION (and year of diagnosis)

- ☐ CVID ☐ Dermatomyositis
☐ PI ☐ Other (specify): _____

4. INSURANCE INFORMATION

Please submit copies of the front and back or primary and secondary insurance cards with this referral.

5. PRESCRIPTION INFORMATION (requires new order every 12 months)

IMMUNE GLOBULIN

Administer ____GMS at ____mg/kg every ____weeks
Concentration ____%
Infusion rate: Start ____ml/hr Max ____ml/hr
Ramp up: Every ____min by ____ml/hr
Hydration (normal saline): ☐ N/A
☐ Pre IG ____ml ☐ Post IG ____ml

- ☐ Vital signs per HI Protocol
☐ Anaphylaxis & Hydration Management
per HI Protocol

PRE-MEDICATIONS ☐ N/A

- ☐ Acetaminophen ☐ 500mg ☐ 650mg ☐ 1000mg PO
☐ Fexofenadine (Allegra) 180mg PO (or other non-sedating anti-histamine)
☐ Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV (requires driver)
☐ Methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 80mg ☐ 125mg IV
☐ Prednisone ____mg PO
☐ Other: _____

POST-MEDICATIONS ☐ N/A

- ☐ Acetaminophen ☐ 500mg ☐ 650mg ☐ 1000mg PO
☐ Prednisone ____mg PO
☐ Other: _____

6. LABS

- | | | |
|--|--|---|
| <input type="checkbox"/> CBC w/Diff | <input type="checkbox"/> each infusion | <input type="checkbox"/> Other frequency (specify): _____ |
| <input type="checkbox"/> CRP | <input type="checkbox"/> each infusion | <input type="checkbox"/> Other frequency (specify): _____ |
| <input type="checkbox"/> CMP | <input type="checkbox"/> each infusion | <input type="checkbox"/> Other frequency (specify): _____ |
| <input type="checkbox"/> ESR | <input type="checkbox"/> each infusion | <input type="checkbox"/> Other frequency (specify): _____ |
| <input type="checkbox"/> Hepatic Panel | <input type="checkbox"/> each infusion | <input type="checkbox"/> Other frequency (specify): _____ |
| <input type="checkbox"/> IgG | <input type="checkbox"/> each infusion | <input type="checkbox"/> Other frequency (specify): _____ |
| <input type="checkbox"/> Renal Panel | <input type="checkbox"/> each infusion | <input type="checkbox"/> Other frequency (specify): _____ |
| <input type="checkbox"/> Quantiferon TB Gold, annually, last completed (date): _____ | | |
| <input type="checkbox"/> Other (specify): _____ | | |

7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE

DATE