



# Indiana University Health

## Immunoglobulin Home Health Infusion Referral

<b>To:</b> IU Health Home Care <a href="mailto:infusionhomecare@iuhealth.org">infusionhomecare@iuhealth.org</a> <b>Fax</b> (317) 962-4737 * <b>Phone</b> (317) 963-4919		<b>***For NON-IU HEALTH physician referrals, please attach patient demographics, insurance, and clinic notes.***</b>
<b>From:</b>		<b>Today's Date:</b>
<b>Phone:</b>	<b>Fax :</b>	<b>ICD-10/Diagnosis:</b>
<b>Patient Name:</b>	<b>Patient Weight:</b> _____ kg or _____ pounds	
<b>DOB:</b>	<b>MRN:</b>	<b>Patient Height:</b> _____ cm or _____ inches

☒ **Home Infusion Therapy and Skilled Nursing Visits for Administration/Assessment / Education**

**Immune Globulin:** ☐ No brand preference ☐ Preferred product \_\_\_\_\_

**Directions:** ☐ Infuse IV ☐ Infuse SC ☒ Per manufacturer guidelines or as written: ☒ May round to the nearest 5gm vial size

**Initial:** \_\_\_\_\_ gm/kg divided over \_\_\_\_\_ days; OR Other: \_\_\_\_\_

**Ongoing:** \_\_\_\_\_ gm/kg divided over \_\_\_\_\_ days, every \_\_\_\_\_ weeks for \_\_\_\_\_ cycles; OR ☐ Other: \_\_\_\_\_

**Quantity/Refills:** ☐ 1-month supply; re ill x 12 months unless otherwise noted ☐ Other: \_\_\_\_\_

**Pre-medications 30 minutes before start of IG:**

☐ Acetaminophen PO ☐ 325 mg ☐ 650 mg \_\_\_\_\_ mg ☒ Diphenhydramine ☐ PO ☐ IV ☐ 25mg ☐ 50mg \_\_\_\_\_ mg

☐ Hydration, solution: \_\_\_\_\_ Volume: \_\_\_\_\_ mL/hr: \_\_\_\_\_

<b>Has patient had this drug before?</b>	<input type="checkbox"/> Yes, date last given _____ Next dose due on _____ <input type="checkbox"/> No
<b>Hypersensitivity Reaction/Treatment</b>	<input checked="" type="checkbox"/> IUHHC Anaphylaxis Adverse Drug Reaction Protocol if required per Home Care Approved Medication policy. Pharmacy to dispense epinephrine, diphenhydramine, and Normal Saline per IUHHC protocol
<b>IV Access</b>	<input type="checkbox"/> PIV - RN to place peripheral line at home and discontinue once IV therapy completed <input type="checkbox"/> Port – supplies and flushes per IUHHC catheter maintenance protocol
<b>Labs</b>	<input type="checkbox"/> Labs and frequency _____

Physician Name (printed) \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

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