Indiana University Health

Immunoglobulin Home Health Infusion Referral

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

Has patient had this drug before?	☐ Yes, date last given_____Next dose due on_____ ☐ No
Hypersensitivity Reaction/Treatment	☒ 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
IV Access	☐ PIV - RN to place peripheral line at home and discontinue once IV therapy completed ☐ Port – supplies and flushes per IUHHC catheter maintenance protocol
Labs	☐ Labs and frequency_____

Physician Name (printed) _____

Physician Signature_____Date _____