



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:	Today's Date:
Phone: Fax :	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 fill 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?	<input type="checkbox"/> Yes, date last given _____ Next dose due on _____ <input type="checkbox"/> No
Hypersensitivity Reaction/Treatment	<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
IV Access	<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
Labs	<input type="checkbox"/> Labs and frequency _____

Physician Name (printed) _____

Physician Signature _____ Date _____

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