PURE INFUSION SUITES

Fax form to: 1-801-931-2631

You must enter a 1 before the fax number

INFUSION ORDERS IVIG

Patient's Information

Date of Referral

First Name | Last Name | M.I.

Date of Birth

Address

City | State | ZIP Code

Phone

WT (kg) | HT (in)

Diagnosis

Allergies

***Please fax most recent CBC and Chemistry Screen.**

*ICD 10 CODE

*** Please include supporting clinical documentation for the specified ICD 10 Code as well as demographic and insurance information. This is necessary to ensure payment by the insurance carrier. Please fax with this order form. Initial appointment date and time will be verified after insurance approval.**

IVIG TREATMENT

(Choose one)

- ☐ Asceniv
- ☐ Bivigam
- ☐ Gamastan SD
- ☐ 10% Gammagard
- ☐ Gammaplex
- ☐ Gammaked
- ☐ Gamunex
- ☐ Immunoglobulin 5%
- ☐ Octagam 10%
- ☐ Panzyga

PRE MEDS

Benadryl:
- ☐ IV
- ☐ PO
- ☐ PRN
- ☐ 25mg
- ☐ 50mg

Tylenol:
- ☐ 650mg PO
- ☐ 1000mg PO
- ☐ PRN

IV Fluids:
- ☐ 250ml normal saline
- ☐ PRN

Other:

POST MEDS

IV Fluids:
- ☐ 250ml normal saline
- ☐ PRN

Other:

Specific dose, route and frequency

Prescribing Provider

Address

City | State | ZIP Code

Provider Signature | Date/Time

Provider Phone | Provider Fax