

American River Infusion:  
3855 North Freeway Boulevard, Suite 110,  
Sacramento, CA 95834

# IVIg / SCIg Referral



Ph 916-239-7900 Fax: 916-239-7800

## PATIENT INFO

**PLEASE ATTACH: DEMOGRAPHICS - COPY OF INSURANCE CARD(S) - PROGRESS NOTES - LABS**

Patient Name:

DOB:

## CLINICAL INFO

Wt: \_\_\_\_\_ Height: \_\_\_\_\_ Has received previous IG therapy \_\_\_\_\_ Date of last infusion \_\_\_\_\_

Allergies: \_\_\_\_\_ Diabetes \_\_\_\_\_

Last IG level: \_\_\_\_\_ Igg: \_\_\_\_\_ IgA: \_\_\_\_\_ Line type:  PIV  Mid line  Port  PICC  Other

## DIAGNOSIS

- |  |  |
|--|--|
| <input type="checkbox"/> Primary immune deficiency – Code _____        | <input type="checkbox"/> G60.9 Multifocal Motor Neuropathy                               |
| <input type="checkbox"/> D83.9 Common Variable Immunodeficiency (CVID) | <input type="checkbox"/> G61.81 Chronic Inflammatory Demyelinating Polyneuropathy (CIPD) |
| <input type="checkbox"/> D50.1 Hypogammaglobulinemia                   | <input type="checkbox"/> G70.01 Myasthenia Gravis  |
| <input type="checkbox"/> G35 Multiple Sclerosis                        | <input type="checkbox"/> Other: _____  |
| <input type="checkbox"/> Idiopathic Thrombocytopenic Purpura (ITP)     |  |

## PRESCRIPTION

American River Clinical Pharmacist to recommend proper dose, route and frequency:  Yes  No

### OR

SQIG Order: Product \_\_\_\_\_ Gm \_\_\_\_\_ SQIG to be infused as directed once weekly  
Refill x \_\_\_\_\_ Month \_\_\_\_\_

### OR

IVIg Product \_\_\_\_\_  Privigen 10% (*pharmacy preferred*)  
\_\_\_\_\_ mg/kg/day \_\_\_\_\_ day(s) every month for \_\_\_\_\_ months  
OR  
\_\_\_\_\_ gm/day \_\_\_\_\_ day(s) every month for \_\_\_\_\_ months  
OR  
Other \_\_\_\_\_

Flushes Per pharmacy protocol

**Pre Meds:**  Diphenhydramine \_\_\_\_\_ mg  PO  Inj.  APAP (Tylenol) \_\_\_\_\_ Mg  Other \_\_\_\_\_

PRN for Anaphylaxis:  Epinephrine 0.3mg IM  Hydrocortisone 100mg IV push  NaCl 0.9%  250ml  500ml

Signing this form and utilizing our services, you are authorizing Home infusion Group, Inc and its's employees to serve as your authorization designated agent for medical and prescription insurance companies

Prescriber Signature \_\_\_\_\_

Date \_\_\_\_\_

Name: \_\_\_\_\_

Address \_\_\_\_\_

City State Zip \_\_\_\_\_

DEA# \_\_\_\_\_

License# \_\_\_\_\_

NPI# \_\_\_\_\_

**IMPORTANT NOTICE:** This Fax is intended to be delivered only to the named addressee. If contains material that is confidential, privileged, propriety or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.