# of Pages Faxed: _____
Fax Referral To: (440) 443-0700
Phone: (216) 381-3333

Immune Globulin
Neurology Referral Form

OIS Ohio Infusion Services

Date Required: _____ Ship To: ☐ Home ☐ Office ☐ Other: _____

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Alternate Phone: _____
Date of Birth: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
DEA #: _____ NPI #: _____
Contact Person: _____

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance: _____ ID: _____ Group: _____
Secondary Insurance: _____ ID: _____ Group: _____
Prescription Card: _____ ID: _____ BIN: _____ PCN: _____

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

DIAGNOSIS

Neurological:

☐ G61.81 Chronic Inflammatory Demyelinating Polyneuropathy
☐ (CIDP) M33.10 Dermatomyositis
☐ G61.0 Guillian-Barré Syndrome
☐ G70.80 Lambert-Eaton Syndrome
☐ G62.89 Multifocal Motor Neuropathy (MMN)
☐ G35 Multiple Sclerosis (Relapsing/Remitting)
☐ G70.01 Myasthenia Gravis w/Acute Exacerbation
☐ G62.9 Polyneuropathy, Unspecified
☐ M33.22 Polymyositis
☐ G25.82 Stiff-Person Syndrome
☐ Other: _____

PATIENT EVALUATION

Has patient previously received IVIG? ☐ Yes ☐ No
Patient Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ cm ☐ in
Allergies: _____
Line Access: ☐ Peripheral ☐ PICC ☐ Port
Delivery Method: ☐ Infusion Pump ☐ Other: _____
Therapy Start Date: _____ Therapy End Date: _____

☐ Patient demographics, including insurance information.
☐ Labs – Antibody testing results, most recent BUN/SCr and IgA level
☐ H&P
☐ Medications/Therapies tried and failed
☐ Baseline assessment, including detailed patient symptoms
☐ Please attach original prescription orders

As Appropriate:
☐ Nerve Conduction Study results, including velocities
☐ Biopsy results
☐ Electromyography (EMG) results
☐ CSF studies
☐ Other: _____

PRESCRIPTION INFORMATION

Immune Globulin Prescription:

Loading Dose: IVIG _____ gm/kg given over _____ day(s) OR _____ gm daily for _____ day(s)

Maintenance: IVIG _____ gm/kg given over _____ day(s) OR _____ gm daily for _____ day(s)

☐ Repeat course every _____ week(s) x _____ course(s)
☐ Refill x _____ (length of time)

Subcutaneous Prescription:

IG _____ gm monthly OR _____ gm every _____ weeks.
Administer SCIG using _____ sites at a time. Repeat _____ week(s). Refill x 1yr.

☐ OK to round to the nearest vial size+/- 4 ☐ days to allow scheduling flexibility

Multiple doses will be administered on consecutive days unless ordered otherwise.
☐ non-consecutive days only

PREMEDICATION ORDERS/OTHER MEDICATIONS

Flush Protocol

☐ NaCl 0.9% 5ml
☐ NaCl 0.9% 10ml
☐ Heparin 10 units/ml
☐ Heparin 100 units/ml
☐ 250ml 0.9% NaCl for hydration
☐ Other: _____

Pre-Medications & Other Medications

☐ Infusion supplies as per protocol
☐ Anaphylaxis Kit orders as per protocol
☐ Acetaminophen _____ mg PO prior to infusion
☐ Diphenhydramine _____ mg PO

Prescriber Signature: _____ **Date:** _____