

DEMOGRAPHICS **PRESCRIBING PHYSICIAN**

Patient Name: _____ Name: _____
 Address: _____ Address: _____
 City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____
 DOB: ___/___/___ Male Female Phone: _____ Fax: _____
 Phone: _____ License#: _____
 SSN: _____ Ht: _____ Wt: _____ DEA#: _____ NPI: _____

ALLERGIES / REACTIONS

Signature: _____
 Date: _____

PHYSICIAN ORDERS

IMMUNOGLUBLIN – IV _____ **REFILLS:** _____
 INFUSE _____ MG/KG over _____ days – REPEAT every _____ WEEKS

Peripheral IV - Flush with Normal Saline 5–10 ml with IV start and before & after medication
 Subcutaneous Port - Flush with Normal Saline 10 ml before & after medication.
 LOCK with Heparin 500 units (100 units/ml)

PRE-MEDICATIONS / LABS **REFILLS:** _____

Diphenhydramine 25 MG IV 30 minutes before infusion
 Solu-Medrol 125 MG IV – 30 minutes before infusion
 OTHER: _____
 LABS: _____

Anaphylaxis Kit per Pharmacy protocol
 TO BE ADMINISTERED BY THE HEALTH CARE PROVIDER **PRN** FOR PATIENTS RECEIVING IV MEDS IN THE HOME
 Epinephrine Auto Injector 0.3mg/0.3ml IM – Repeat one time in 20 minutes if needed

ADVERSE REACTION ORDERS:
Mild Reactions - Reduce rate by 1/2 at time of onset and keep reduced x30 minutes. If resolved, increase per guidelines. If not resolved, administer appropriate medication based on symptoms,
Severe Reactions - STOP infusion, KVO IV Normal Saline _____ Diphenhydramine 25/50 mg IVP over 3-5 minutes _____
 Methylprednisolone 125 mg IVP over 5 minutes _____ Call Ambulance and Physician.

DIAGNOSIS:

_____ _____