

Intravenous Immune Globulin (IVIG) Order Form

Patient Name: _____ DOB: _____

Diagnosis: _____ Diagnosis Code: _____

Height: _____ (cm) Actual Weight: _____ (kg) Allergies: _____

PREMEDICATION - Administer if patient has not already taken

*In the event of a hypersensitivity reaction, patients will be treated according to NECS protocols for the management of infusion-room drug reactions.

- None
- Acetaminophen 1000 mg orally x 1 dose prior to IVIG
- Diphenhydramine 25 mg IV x 1 dose prior to IVIG (pt will need a driver home)
- Diphenhydramine 50 mg IV x 1 dose prior to IVIG (pt will need a driver home)
- Hydrocortisone 100 mg IV x 1 done prior to IVIG
- Other _____

DOSE: Round to nearest 5 gm dose.

- * The preferred IVIG at New England Cancer Specialists is Gammagard 10%.
- * If a different IVIG product is needed, indicate the brand *and* clinical rationale below

- Gammagard 10% _____ g/kg (J1569)
- Other _____

Total IVIG Dose = WT (kg) x Dose (g/kg) =

RATE OF INFUSION IVIG will be infused according to NECS standard unless otherwise ordered

- Other _____

FREQUENCY OF ADMINISTRATION

- x 1 dose only
- Daily x _____ doses
- Weekly x _____ doses
- Monthly x _____ doses
- Other _____

Provider Name: _____

Provider Signature: _____ Date: _____

Phone: _____ Fax: _____ Pager: _____