

Intravenous Immune Globulin (IVIG) Order Form

Patient Name Middle Last 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