Patient: ______________________________

IVIG THERAPY REFERRAL FORM

Patient Name:			Date of Birth:
Address:			
City:		State:	Zip Code:
Home Phone:		Alternate Phone:	
Allergies:			
Height:	Weight:	Type of Access:	

Prescription Information:

RX: IVIG _______ grams and QD _______days

1st Hour Infusion Rate ____________ cc/hr 2nd Hour ____________ cc/hr   Thereafter ____________ cc/hr

Repeat/maintenance treatment in: ____________________ or every _______ / month

Blood Test:

CBC, Metabolic panel (chem-7) daily, prior to each infusion.
Immunoglobulins quantitation (Before 1st/ ________ Treatment), Fax results.

❑ Other: ____________________________________

Nursing:

❑ Plaza to coordinate nursing services   ❑ MD's office will coordinate nursing

❑ Home Health Agency: _______________________   ❑ Nursing will NOT be required

Delivery Instruction:

❑ Patient's Home   ❑ Infusion Suite   ❑ Physician's Office

❑ Other: ____________________________________

Following Physician Name:	Phone:
Prescribing Physician Name:	Phone:
Signature:	Date:

Fax completed form to (626) 585-8031

900 S Arroyo Pkwy. Unit #150 Pasadena, CA 91105

Tel: (626) 585-8521   Fax: (626) 585-8031   1 800-RX Plaza

www.plazahomecarepharmacy.com