vitalcare of LITTLE ROCK
Fountains Infusion Center
15200 Chenal Pkwy. Suite 300 Little Rock AR
Phone 501-451-6080 Fax501-451-6081

IVIG
INFUSION ORDERS

****REQUIRED INFORMATION****

☐ This signed order form from the provider
☐ Patient demographics & insurance information
☐ **Clinical/Progress Notes, Labs & Tests** supporting primary diagnosis (ICD-10 below)

Patient Name:	**DOB:**
Allergies:	**Patient Phone:**

Diagnosis:

☐ ____ ☐ (ICD-10: ________________)

Pt. Weight ___________ kg Allergies:____

IVIG ORDERS

Pharmacist to identify clinically appropriate brand/infusion rates. May substitute based on product availability.

Do not substitute. Administer brand: ______________________

- *Infuse entire contents of Ig infusion bag/vial(s) per current dose.*
- *If needed, round dose to nearest whole 5 gm vial for IV doses.*

Loading Dose: __________________ mg/kg IV x _____ day(s) or divided over _________day(s)
grams/kg
grams

Maintenance Dose:_______________ mg/kg IV x _____ day(s) divided over _________day(s)
grams/kg
grams

Frequency: Every____________weeks or ☐ ____________one time dose **Refills:**_________________

Protocol Pre-Medication Orders: Tylenol 650mg PO, *please choose one antihistamine:*

☐ Cetirizine 10mg PO
☐ Diphenhydramine 25mg PO
☐ Loratadine 10mg PO

Additional Pre-Medication Orders:

Solu-Medrol __________ mg IVP
NS 0.9% __________ mL IV
Zofran 4mg IV
Other____

Additional Instructions/Labs:

Physician Name:	**Phone:**	**Fax:**
****Physician Signature:**	**Date:**	