VEROS HEALTH
Excellence in Complex Care

Immunology Referral Form

Please complete the following and fax with clinical documentation to: 720.279.7461

Referral Process

1. PATIENT INFORMATION			2. PHYSICIAN INFORMATION		
Name:			Physician's name:		
Address:			Address:		
City:	State:	Zip:	City:	State:	Zip:
Home Phone:	Other Phone:		Office Contact:		
Email:			Phone:	Fax:	
DOB:	Social Security #:		NPI:		

Gender: ☐ M ☐ F Height: Weight:

Allergies: ____

3. DIAGNOSIS Year of diagnosis: _____

- ☐ Hereditary Hypogammaglobulinemia (D80.0)
- ☐ Selective deficiency of immunoglobulin A (IgA) (D80.2)
- ☐ Selective deficiency of immunoglobulin G (IgG) subclasses (D80.3)
- ☐ Selective deficiency of immunoglobulin M (IgM) (D80.4)
- ☐ Immunodeficiency with Increased immunoglobulin M (IgM) (D80.5)
- ☐ Antibody deficiency with near-normal immunoglobulins or with hyperimmunoglobulinemia (D80.6)
- ☐ Transient hypogammaglobulinemia of infancy (80.7)
- ☐ Severe combined immunodeficiency (SCID) with reticular dysgenesis (D81.0)
- ☐ Severe combined immunodeficiency (SCID) with low T and B cell numbers (D81.1)
- ☐ Severe combined immunodeficiency (SCID) with low or normal B cell numbers (D81.2)
- ☐ Purine nucleoside phosphorylase (PNP) deficiency (D81.5)
- ☐ Major histocompatibility complex class I deficiency (D81.6)
- ☐ Major histocompatibility complex class II deficiency (D81.7)
- ☐ Other Combined Immunodeficiencies (D81.89)
- ☐ Combined Immunodeficiencies, unspecified (D81.9)
- ☐ Wiskott-Aldrich Syndrome (D82.0)
- ☐ Di George's syndrome (D82.1)
- ☐ Hyperimmunoglobulin E (IgE) syndrome (D82.4)
- ☐ Common variable immunodeficiency with predominant abnormalities of B-cell numbers (D83.0)
- ☐ Common variable immunodeficiency with predominant immunoregulatory T-cell disorders (D83.1)
- ☐ Common variable immunodeficiency with autoantibodies to B or T cells (D83.2)
- ☐ Other common variable immunodeficiencies (D83.8)
- ☐ Common variable immunodeficiency (CVID), unspecified (D83.9)
- ☐ Other Specified Immunodeficiencies (D84.8)
- ☐ Primary Immunodeficiencies (D84.9)
- ☐ Cerebellar ataxia with defective DNA repair (G11.3)
- ☐ Other(s):

4. INSURANCE INFORMATION

Please submit copies of the front and back of primary and secondary insurance cards with this referral.

5. ADDITIONAL INFORMATION REQUESTED

Has the Patient Received IVIG Previously? ☐ No ☐ Yes   Product: ______________________________   Date of last dose: _____

Last BUN/CR _____   ☐ IgA level _____   ☐ H&P   ☐ Infection History   ☐ Baseline IgG level

☐ Immune Response to Vaccines

6. PRESCRIPTION INFORMATION   Anticipated Start Date: _____

Immune Globulin Product: ____ ☐ IV ☐ SQ

☐ SCIG pre-filled syringe option, if appropriate for patient ☐ Not applicable

Administer _____ grams daily for _____ day(s) OR _____ milligrams/kilogram daily over _____ day(s)

Repeat course every _____ week(s) for a total of _____ courses/cycles

☐ Pre-hydrate with: ☐ NS ☐ D5W ☐ Other: _____   _____ ml IV over _____ hours

☐ Pre medicate:

- ☐ Acetaminophen 325-650mg PO prior to IG and then Q4-6 hours as needed during infusion
- ☐ Diphenhydramine 25-50 mg PO prior to IG
- ☐ Other premedication: ____________________

☐ Post-hydrate with: ☐ NS ☐ D5W ☐ Other: _____   _____ ml IV over _____ hours

Provide supplies necessary to maintain IV Access: ☐ PIV ☐ Midline/PICC ☐ Port

Administration method: ☐ Pump ☐ Dial-a-flow

7. FLUSH ORDERS

PIV/midline/PICC: Flush before, after each infusion, and as needed with 3-20 ml NS, followed by Heparin 2-5 ml if indicated

☐ Heparin 10 unit/ml   ☐ Heparin 100 unit/ml

Port: Flush before, after each infusion, and as needed with 5-20 ml NS, followed by Heparin 100 unit/ml 5 ml. (Use Heparin 10 unit/ml for patients <2 years old)

8. ANAPHYLAXIS ORDERS

Adults: For mild reaction-administer diphenhydramine 50mg IVP/PO x 1.

For severe reactions-administer epinephrine 0.3mg SubQ/IM x 1. May repeat x1 if needed. Contact 911 and monitor vital signs.

Pediatrics: administer by age: *For mild reaction (rash/hives) give diphenhydramine*

Age 1-5: 12.5mg IV/PO x1   **Age 6-11**: 25mg IV/PO x1   **Age 12+**: 50mg IV/PO x1

For severe reaction (airway closure) administer epinephrine. 0.01mg/kg/dose (max 0.3mg) SubQ/IM x 1.

If needed, repeat a second dose after 5-10 minutes for a maximum of two doses. Contact 911 and monitor vital signs.

☐ Other: ____________________

9. NURSING ORDERS

Skilled nursing to insert, maintain and remove/de-access vascular access daily, weekly and/or as needed, draw labs as ordered, conduct patient assessments, and educate patient/caregiver on home infusion, medication administration, self-monitoring, and patient safety.

Skilled Nursing Services Needed? ☐ Yes ☐ No   Additional Instructions: _____

10.

☐ Dispense as written ☐ Substitution Permitted

PHYSICIAN'S SIGNATURE (required): ________________________________ **Date:** _____

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Prescription is valid for one year unless otherwise indicated. The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.