

Immunology Referral Form

Please complete the following and fax with clinical documentation to: 720.870.2414

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