vitalcare® of the FOUR STATES

IMMUNOGLOBULIN ORDER FORM

Vital Care of the Four States, 109 E Hickory St., Neosho, MO 64850
OFFICE 417-451-7900 / FAX 417-451-7915

DEMOGRAPHICS

Patient Name: _____

Address: _____

City: _____ State: ____ Zip:_____

DOB: ____/____/____ ☐ Male ☐ Female

Phone: _____

SSN: _____ Ht: _____ Wt: _____

PRESCRIBING PHYSICIAN

Name: _____

Address: _____

City: _____State: _____ Zip: _____

Phone: _____ Fax: _____

License#: _____

DEA#: _____NPI: _____

Signature: _____

Date: _____

ALLERGIES / REACTIONS

_____

_____

PHYSICIAN ORDERS

☑ **IMMUNOGLUBLIN – SQ** _____ **REFILLS:** _____

INFUSE _____ GMS OR _____ MLS USING _____ SITES

EVERY _____ DAYS - DISPENSE 1MONTH AT A TIME

☑ **ANCILLARY SUPPLIES should include appropriate supplies to perform weekly infusions**

☐ **PRE-MEDICATIONS / LABS** **REFILLS:** _____

☐ Diphenhydramine 25 MG PO or IV (circle) 30 -60 minutes before infusion

☐ Solu-Medrol _____ MG IV – 30 minutes before infusion

☐ OTHER: **EMLA Cream 5% - apply 30 minutes to 1 hour prior to infusion**

☐ LABS: _____

☐ **Anaphylaxis Kit per Pharmacy protocol**

TO BE ADMINISTERED BY THE HEALTH CARE PROVIDER **PRN** FOR PATIENTS RECEIVING IV MEDS IN THE HOME
Epinephrine Auto Injector 0.3mg/0.3ml IM – Repeat one time in 20 minutes if needed

☐ **ADVERSE REACTION ORDERS:**

Mild Reactions - Reduce rate by 1/2 at time of onset and keep reduced x30 minutes. If resolved, increase per guidelines. If not resolved, administer appropriate medication based on symptoms,
Severe Reactions - STOP infusion, KVO IV Normal Saline ____ Diphenhydramine 25/50 mg IVP over 3-5 minutes _____
Methylprednisolone 125 mg IVP over 5 minutes _____ Call Ambulance and Physician.

DIAGNOSIS:

☐ _____ ☐ _____