Comanche County Memorial Hospital

IVIG Order Form

Phone: 580-250-5899 | Fax: 580-585-5472

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

HT: _____ WT: _____ DOB: _____ Sex: ( ) Male ( ) Female SSN: _____

Street Address _____ _____ City/Stale/Zip _____

Home Phone # _____ Work # _____ Cell # _____

INSURANCE INFORMATION

Primary Insurance Name _____ Policy ID# _____

Secondary Insurance Name _____ Policy ID# _____

PHYSICIAN/FACILITY INFORMATION

Physician's Name _____ Contact Name _____ Contact Phone # _____

Address _____ City/State/Zip _____ Fax #: _____

DEA# _____ NPI# _____ State License # _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis (ICD 10 code AND CPT code) _____

Secondary Diagnosis (ICD 10 code AND CPT code) _____

MEDICAL INFORMATION

Does the patient have venous access? ☐ Yes ☐ No If Yes, what type? _____

Is the patient incontinent? ☐ Yes ☐ No Comments: _____

Is the patient ambulatory? ☐ Yes ☐ No Comments: _____

***ALL MEDIPORTS/PORTS/VAD, ETC. WILL BE ACCESSED AND FLUSHED WITH HEPARIN PER HOSPITAL PROTOCOL**

***50 mL BAG OF NORMAL SALINE WILL BE HUNG TO CLEAR ALL PATIENT LINES**

Specify Brand Preferred (limited availability, substitution may apply): _____

Infuse ☐ _____ gm or ☐ _____ mg/kg over _____ hours as directed every _____ weeks or _____ days

PRN MEDICATIONS:

Bendaryl PRN: _____ mg ☐ PO ☐ IV ☐ IVP Acetaminophen PRN: _____ mg ☐ PO ☐ IV ☐ IVP

Other: _____ Oxygen: _____

FLUSHES:

☑ **10 mL NS Flush Syringe PRN** ☑ **Heparin 500units/5mL Flush Syringe PRN** ☑ **10 mL NS Flush Syringe PRN** ☑ **250mL NS PRN**

LABS: _____

NOTES: _____

_____

Physician's Signature _____ Date: _____ Time: _____

Fax completed form to the Outpatient Infusion Center at 580-585-5472. PLEASE include copies of: H&P, OFFICE NOTES, LABS, ACTIVE MEDICATION PROFILE, LETTER OF NECESSITY or any other documentation supporting the use of infusion therapy, and ALL current insurance information for your referral to be processed.