TALIS HEALTHCARE

Immune Globulin Referral Form

RETURN COMPLETED FORM VIA FAX TO:
888.898.9113

PATIENT INFORMATION (Complete or fax existing chart)

Patient Name: _____
Address: _____
City, State, Zip: _____
Phone: _____ Alt Phone: _____
DOB: _____ Gender: M F Last 4 SSN: _____
Weight: HT: Allergies:

PRESCRIBER INFORMATION

Prescriber Name: _____
State License: _____ NPI #: _____
DEA: _____ Phone: _____
Address: _____ Fax: _____
City, State, Zip: _____
Contact Person: _____ Phone: _____

INSURANCE INFORMATION - INSTEAD - just send us a copy of the patient's prescription / insurance cards (front & back)

Primary Insurance: _____ RX Card (PBM): _____
City, State, Zip: _____ BIN: _____ PCN: _____
Plan #: _____ City, State, Zip: _____
Group #: _____ Group #: _____
Phone: _____ Phone: _____

DIAGNOSIS /CLINICAL INFORMATION

☐ D80.0 Congenital Hypogammaglobinemia	☐ D81.9 SCID (unspecified)	☐ D83.9 Common Variable Immunodeficiency
☐ G35 MS (Relapsing Remitting)	☐ G61.0 GBS	☐ G61.81 CIDP
☐ G61.89 MMN	☐ G70.01 MG W/ acute exacerbation	☐ M33.20 Polymyositis
☐ M33.90 Dermatomyositis		
☐ Other Code:	Description:	

Needs by Date: Ship to: Patient Office Other:
Lab Orders:

PRESCRIPTION / ADMINISTRATION

Medication	Route	Dose	Directions	Refills
Immune Globulin Brand (any): ☐ Dispense As Written	☐ SC ☐ IM ☐ IV	_____grams _____g/kg	IV or Sub -____gm once daily for____days Repeat every____weeks for total of_____Course/Courses	#:_____

Pre-Meds	Route	Dose	Directions	Quantity	Refills
☐ Acetaminophen	☐ PO	☐ 325mg ☐ 500mg ☐ _____	☐ Pre-Med: _____ ☐ _____	☐ w/ea. Infusion ☐ _____	#:_____
☐ Diphenhydramine	☐ PO ☐ IM ☐ IV	☐ 25mg ☐ 50mg	☐ Pre-Med: _____ ☐ PRN Reaction: _____	☐ w/ea. Infusion ☐ _____	#:_____
☐ Methylprednisolone					
☐ Ondansetron					
☐ Reglan					
☐ Other					
Flush					
☐ Saline 10mL	☐ IV	☐ 3 mL ☐ 5 mL ☐ _____	☐ Before and after infusion ☐ _____	☐ w/ea. Infusion ☐ _____	#:_____
☐ Heparin - 10 Units/ml ☐ Heparin - 100 Units/ml	☐ IV	☐ 3 mL ☐ 5 mL ☐ _____	☐ After infusion ☐ _____	☐ w/ea. Infusion ☐ _____	#:_____
Anaphylaxis					
☐ Diphenhydramine	☐ IV ☐ PO ☐ IM	☐ 25mg ☐ 50mg ☐ _____	☐ Pre-Med: _____ ☐ _____	☐ w/ea. Infusion ☐ _____	#:_____
☐ Epinephrine	☐ IM ☐ SQ	☐ Adult 1:1000 0.3mL ☐ Peds1:2000 0.3mL	☐ PRN Anaphylaxis ☐ Repeating Dose: _____	☐ Once ☐ _____	#:_____
☐ Epipen (2 pack)	☐ IM ☐ SQ				#:_____
☐ Other:					
Vascular Access method	☐ Peripheral	☐ Central	☐ Other _____		

SIGNATURE

X _____ Date: _____

Product Substitution Permitted

Thank you for using Talis Healthcare