IVIG Infusion Order
(Gammagard)

SMART CHOICE INFUSION
FOR YOUR HEALTH & WELLNESS

www.smartchoiceinfusion.com
Ph: 818-659-8182
Fax: 818-659-8990

Date: _____ Treatment Location: _____

*Please fax a copy of the following patient information: ❒ Demographics ❒ Insurance Information ❒ Current CBC & CMP ❒ H & P Relevant to the Diagnosis ❒ Current Medications

PATIENT INFORMATION

Patient Name: _____

DOB: _____

Allergies: _____

Weight: _____ ◯ lbs / ◯ kg Height: _____

Diagnosis: _____

ICD-10: _____

PROVIDER INFORMATION

Printed Provider's Name: _____

Signature: _____

NPI: _____ Date: _____

Phone: _____ Fax: _____

Office Address: _____

Contact Person: _____

Contact Email: _____

PRE-MEDICATIONS:

Benadryl:	❒ PO	❒ IV	❒ 25mg	❒ 50mg	❒ Pre-med	❒ PRN
Acetaminophen:	❒ PO		❒ 650mg		❒ Pre-med	❒ PRN
Zyrtec:	❒ PO		❒ 10mg		❒ Pre-med	❒ PRN
Solu-Medrol:		❒ IV	❒	mg	❒ Pre-med	❒ PRN
Normal Saline:		❒ IV	❒	mL		❒ PRN

IVIG (GAMMAGARD) IV DOSAGE:

Date of Last Treatment, If Continuation:

10% Immunolobin solution (_____ gm/kg): = _____ gm

Frequency: _____ Duration: _____

Start Date of Infusion: _____