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**(888) 219-8102**

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# IVIG THERAPY REFERRAL FORM

PATIENT DEMOGRAPHICS:				
PATIENT NAME:	PREFERRED CONTACT #:			
DATE OF REFERRAL:	SECONDARY CONTACT #:			
SOCIAL SECURITY NUMBER:	ADDRESS:			
DATE OF BIRTH:	CITY, STATE, ZIP:			
PRIMARY DIAGNOSIS:				
ICD-IO CODE:				
PATIENT INFORMATION:				
ALLERGIES: NKDA <input type="checkbox"/>	FIRST DOSE: <input type="checkbox"/> Y <input type="checkbox"/> N			
	DATE OF LAST INFUSION:			
	NEXT DOSE DUE BY:			
HEIGHT: ___ Ft ___ In      WEIGHT: ___ Lb or ___ Kg	LINE TYPE:			
GENDER: <input type="checkbox"/> F <input type="checkbox"/> M	OTHER:			
REQUIRED DOCUMENTATION: Please provide a copy of the following documents.				
<input checked="" type="checkbox"/> 1. INSURANCE CARD (Front & Back) <input checked="" type="checkbox"/> 2. PATIENT DEMOGRAPHICS <input checked="" type="checkbox"/> 3. MOST RECENT LABS <input checked="" type="checkbox"/> 4. H & P				
PRIMARY MEDICATION ORDER:		PRN & PREMEDICATIONS:		
Please include MEDICATION, DOSE, FREQUENCY, DURATION and any ADDITIONAL administration INSTRUCTIONS specific to the primary therapy.  If weight-based dosing, dose on the patients: <input type="checkbox"/> ACTUAL BODY WEIGHT <input type="checkbox"/> IDEAL BODY WEIGHT  Round up to nearest vial size? <input type="checkbox"/> YES <input type="checkbox"/> NO		MEDICATIONS	30 minutes prior every infusion	PRN
		Acetaminophen ___ 1000mg PO	<input type="checkbox"/>	<input type="checkbox"/> PRN every ___ hours for mild infusion reaction.
		Diphenhydramine ___ mg PO	<input type="checkbox"/>	<input type="checkbox"/> PRN every ___ hours for mild infusion reaction.
		Diphenhydramine ___ mg diluted in 10mL 0.9% NaCl slow IV push over 2-3 minutes.	<input type="checkbox"/>	<input type="checkbox"/> PRN every ___ hours for mild infusion reaction.
		Methylprednisolone ___ mg IV push over 5 minutes.	<input type="checkbox"/>	
		Normal Saline ___ mL over ___ min PRN or prior to every infusion.	<input type="checkbox"/>	
		Other:		
LINE USE/CARE ORDERS:		ADVERSE REACTION & ANAPHYLAXIS ORDERS:		
<input type="checkbox"/> START PIV/ACCESS CVC <input type="checkbox"/> FLUSH DEVICE PER FLEXCARE INFUSION POLICY & PROCEDURE <input type="checkbox"/> OTHER FLUSH ORDERS: (See Reverse Side)		<input type="checkbox"/> ADMINISTER ACUTE INFUSION AND ANAPHYLAXIS MEDICATIONS PER FLEXCARE INFUSION POLICY AND PROCEDURE (See Reverse Side)  <input type="checkbox"/> OTHER: (please fax other reaction orders if checking this box)		
PRESCRIBER INFORMATION:				
PHYSICIAN NAME:		PHONE:		
OFFICE CONTACT:		FAX:		
ADDRESS:		LICENSE #:		
CITY, STATE, ZIP:		NPI:		
▶▶▶▶▶▶▶▶▶▶▶▶▶▶▶▶ PHYSICIAN SIGNATURE:		DATE:		

**FLEXCARE INFUSION CENTER'S ACUTE & ANAPHYLAXIS MEDICATION PROTOCOL:**

*\*This graph does not reflect non-medicinal interventions that are part of FlexCare's protocol, such as slowing or stopping the infusion and physician/911 notification.*

	<b>MILD INFUSION REACTION</b>	<b>MODERATE INFUSION REACTION</b>	<b>SEVERE INFUSION REACTION/ANAPHYLAXIS</b>
<b>SYMPTOM CLASSIFICATION</b>	<ul style="list-style-type: none"> <li>Flushing</li> <li>Dizziness</li> <li>Headache</li> <li>Apprehension</li> <li>Diaphoresis</li> <li>Palpitations</li> <li>Nausea / Vomiting</li> <li>Pruritis</li> </ul>	<ul style="list-style-type: none"> <li>Chest Tightness</li> <li>Shortness of Breath</li> <li>Hypo/hypertension (&gt;20 mmHg Change in Systolic BP from Baseline)</li> <li>Increased Temperature (&gt;2 Degrees Fahrenheit)</li> <li>Urticaria</li> </ul>	<ul style="list-style-type: none"> <li>Hypo/hypertension (&gt;40 mmHg Change in Systolic BP from Baseline).</li> <li>Increase Temperature (&gt;2 Degrees Fahrenheit) with Rigors</li> <li>Shortness of Breath with Wheezing</li> <li>Laryngeal Edema</li> <li>Chest Pain</li> <li>Hypoxemia</li> </ul>
<b>TREATMENT PROTOCOL FOR ADULTS &gt;66LBS</b>	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Apply oxygen via ambu bag or high flow nasal canula, if vomiting. <input checked="" type="checkbox"/> Administer 0.9% NaCl 500 mL at 125mL/hr to maintain IV access. <input checked="" type="checkbox"/> Administer diphenhydramine 50 mg IV or IM Inject epinephrine 0.3mg/0.3 mL IM into the mid- anterolateral aspect of the thigh; repeat in 5-15 minutes if needed. <input checked="" type="checkbox"/> Administer 0.9%NaCl 1000mL bolus for an incomplete response to IM epinephrine. May repeat x1.
<b>TREATMENT PROTOCOL FOR CHILDREN 33LBS - 66LBS</b>	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Apply oxygen via ambu bag or high flow nasal canula, if vomiting. <input checked="" type="checkbox"/> Administer 0.9% NaCl 500mL at 75mL/hr to maintain IV access. <input checked="" type="checkbox"/> Administer diphenhydramine 1-2 mg/kg IM or slow IVP not to exceed 25 mg/min <input checked="" type="checkbox"/> Inject epinephrine 0.15mg/0.15 mL IM into the mid- anterolateral aspect of the thigh; repeat in 5-15 minutes if needed. <input checked="" type="checkbox"/> Administer 0.9% NaCl bolus 20mL/kg for an incomplete response to IM epinephrine. May repeat x1.

**FOR CHILDREN < 33 LBS FLEXCARE INFUSION UTILIZES THE REACTION ORDERS OBTAINED BY THE REFERRING PHYSICIAN.**

**FLUSHING PROTOCOLS**

PATIENT CLASSIFICATION	LINE TYPE	FLUSHING PROTOCOL Normal Saline*			LOCKING PROTOCOL Heparin Sodium	
		PRE-ADMIN	POST ADMIN	POST LAB DRAW	10 Units/mL	100 Units/mL
<b>ADULT &gt;66 LBS</b>	Peripheral IV Catheter	3 mL	3 mL		3 mL	
	Midline	3 mL	3 mL		3 mL	
	Implanted Port	5 mL	10 mL	10 mL		5 mL
	Peripherally Inserted Central Catheters (PICC)	5 mL	10 mL	10 mL	5 mL	
	Tunneled & non-Tunneled Catheters.	5 mL	10 mL	10 mL	5 mL	
<b>PEDIATRIC 33 LBS - 66LBS</b>	Peripheral IV Catheter	3 mL	3 mL		3 mL	
	Midline	3 mL	3 mL		3 mL	
	Implanted Port	5 mL	5 mL	10 mL	3 mL	
	Peripherally Inserted Central Catheter (PICC)	5 mL	5 mL	10 mL	3 mL	
	Tunneled & non-Tunneled Catheters.	5 mL	5 mL	10 mL	3 mL	

**FOR CHILDREN <33 LBS, FLEXCARE INFUSION UTILIZES THE FLUSHING ORDERS OBTAINED BY THE REFERRING PHYSICIAN.**

\*0.9% NS will be substituted with Dextrose 5% or alternative only when indicated due to medication incompatibility with NS.