



IV Immunoglobulin

Select location:

Akron	Cleveland (North Olmsted)	Liberty	Springfield
Anderson	Columbus (East Broad)	Lima	Toledo
Athens	Columbus (Hilliard)	Mansfield	Troy
Canton	Columbus (Worthington)	Mentor	Warren
Cincinnati (Blue Ash)	Dayton (Beavercreek)	Perrysburg	Youngstown
Cincinnati (West Side)	Dayton (Englewood)	Sandusky	Zanesville
Cleveland (Mayfield)	Findlay	Solon	Crestview Hills (KY)

For new referrals, please include recent labs and last two office visit notes.

Fax completed form to 888-977-0914

Phone: 877-787-8720 • www.horizoninfusions.com

1. PATIENT INFORMATION

Name:		DOB:	
Phone:		Other Phone:	
Email:			
Social Security #:		Allergies:	
Gender: M F		Weight: Lbs Kg	
Patient Status: New to therapy Continuing therapy		Next due date (if applicable):	

2. INSURANCE INFORMATION (required)

Please submit copies of the front and back of primary and/or secondary insurance cards with this referral.

3. PHYSICIAN INFORMATION

Physician Name:		NPI#:	
License #:	TIN#:	DEA#:	
Address:			
City:		State	Zip
Office Contact:		Email:	
Office phone:		Office fax:	

4. DIAGNOSIS INFORMATION (ICD 10 Code Required)

CVID () Dermatomyositis () Other: _____
 PI ()

5. PRESCRIPTION INFORMATION (requires new order every 12 months)

Immune Globulin _____	PRE-MEDICATIONS N/A
Administer _____ GMS at _____ gm/kg	Acetaminophen 500mg 650mg 1000mg
OR	Fexofenadine (Allegra) 180mg PO (or other non-sedating antihistamine)
_____ mg/kg every _____ weeks	Diphenhydramine (Benadryl) 25mg 50mg PO IV (requires driver)
Concentration _____%	Methylprednisolone (Solu-Medrol) 40mg 80mg 125mg IV
Infusion Rate: Start _____ mU/hr	Prednisone _____ mg PO
Max: _____ mU/hr	Other _____
Ramp Up: Every _____ min by _____ mU/hr	POST-MEDICATIONS N/A
Hydration (normal saline):	Acetaminophen 500mg 650mg 1000mg
N/A Pre IG _____ ml Post IG _____ ml	Prednisone _____ mg PO
Vital signs per HI protocol	Other _____
Anaphylaxis & Hydration Management per HI protocol	

6. LABS

CBC w/Diff	Each Infusion	Other Frequency (specify): _____
CRP	Each Infusion	Other Frequency (specify): _____
CMP	Each Infusion	Other Frequency (specify): _____
ESR	Each Infusion	Other Frequency (specify): _____
Hepatic Panel	Each Infusion	Other Frequency (specify): _____
Renal Panel	Each Infusion	Other Frequency (specify): _____
Quantiferon TB Gold, annually, last completed (date): _____		
Other (specify): _____		

7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE

DATE