SOLEO HEALTH
Innovators in Specialty Infusion

www.soleohealth.com
Phone: 888.244.2340

Immunology Referral Form

Please complete the following and fax with clinical documentation to: **844.797.5050 or email to: Centersource@soleohealth.com**

Referral Process

1. PATIENT INFORMATION	2. PHYSICIAN INFORMATION
Name:	Physician's name:
Address:	Address:
City: State: Zip:	City: State: Zip:
Home Phone: Other Phone:	Office Contract:
Email:	Phone: Fax:
DOB: Social Security #:	NPI:

Gender: ☐ M ☐ F Height: Weight:

Allergies: _____

3. DIAGNOSIS Year of diagnosis: _____

- ☐ Congenital Hypogammaglobulinemia (D80.0)
- ☐ CVID (D83.9)
- ☐ Immunodeficiency with Increased IgM (D80.5)
- ☐ Primary Immunodeficiencies (D84.9)
- ☐ Other Specified Immunodeficiencies (D84.8)
- ☐ Combined Immunodeficiencies (D81.9)
- ☐ Other Combined Immunodeficiencies (D81.89)
- ☐ Wiskott-Aldrich Syndrome (D82.0)
- ☐ Other(s):

4. INSURANCE INFORMATION

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

5. ADDITIONAL INFORMATION REQUESTED

Has the Patient Received IVIG Previously? ☐ No ☐ Yes Product: _____ Date of last dose: _____

Last BUN/CR _____ ☐ IgA level _____ ☐ H&P ☐ Infection History ☐ Baseline IgG level

☐ Immune Response to Vaccines

6. PRESCRIPTION INFORMATION Anticipated Start Date: _____

Immune Globulin Product: _____ ☐ IV ☐ SQ

Administer _____ grams daily for _____ day(s) OR _____ grams/kilogram daily over _____ day(s)

Repeat course every _____ week(s) for a total of _____ courses/cycles

☐ Pre-hydrate with: ☐ NS ☐ D5W ☐ Other: _____ _____ ml IV over _____ hours

☐ Pre medicate:

- ☐ Acetaminophen 325-650mg PO prior to IG and then Q4-6 hours as needed during infusion
- ☐ Diphenhydramine 25-50 mg PO prior to IG
- ☐ Other premedication: _____

☐ Post-hydrate with: ☐ NS ☐ D5W ☐ Other: _____ _____ ml IV over _____ hours

Provide supplies necessary to maintain IV Access: ☐ PIV ☐ Midline/PICC ☐ Port Administration method: ☐ Pump ☐ Dial-a-flow

7. FLUSH ORDERS

PIV/midline/PICC: Flush before, after each infusion, and as needed with 3-20 ml NS, followed by Heparin 2-5 ml if indicated

☐ Heparin 10 unit/ml ☐ Heparin 100 unit/ml

Port: Flush before, after each infusion, and as needed with 5-20 ml NS, followed by Heparin 100 unit/ml 5 ml. (Use Heparin 10 unit/ml for patients <2 years old)

8. ANAPHYLAXIS ORDERS

Adults: For mild reaction-administer diphenhydramine 50mg IVP/PO x 1.

For severe reactions-administer epinephrine 0.3mg SubQ/IM x 1. May repeat x1 if needed. Contact 911 and monitor vital signs.

Pediatrics: administer by age: *For mild reaction (rash/hives) give diphenhydramine*

Age 1-5: 12.5ml IV/PO x1 **Age 6-11**: 25mg IV/PO x1 **Age 12+:** 50mg IV/PO x1

For severe reaction (airway closure) administer epinephrine. 0.01mg/kg/dose (max 0.3mg) SubQ/IM x 1.

If needed, repeat a second dose after 5-10 minutes for a maximum of two doses. Contact 911 and monitor vital signs.

☐ Other: _____

9. NURSING ORDERS

Skilled nursing to insert, maintain and remove/de-access vascular access daily, weekly and/or as needed, draw labs as ordered, conduct patient assessments, and educate patient/caregiver on home infusion, medication administration, self-monitoring, and patient safety.

Skilled Nursing Services Needed? ☐ Yes ☐ No Additional Instructions: _____

10. ☐ Dispense as written ☐ Substitution Permitted

PHYSICIAN'S SIGNATURE (required): _____ **Date:** _____

Prescription is valid for one year unless otherwise indicated.
The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.
Not applicable in Arizona, please contact your local Soleo Arizona branch for assistance.