NYC

Borough Park
1428 36th Street
Suite 107
Brooklyn, NY 11218

Queens
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375

Midtown
120 East 56 Street
Suite 3D
New York, NY 10022

Upper East Side
225 E 70th Street
Suite 1E
New York, NY 10021

Sheepshead Bay
2546 East 17th Street
Fl, 1
Brooklyn, NY 11235

Long Island City
36-36 33rd
Suite 311
Long Island City, NY 11106

FIDI
30 Broad Street
Suite 401
New York, NY 10004

Central Park West
115 Central Park West
Suite 15
New York, NY 10023

Bronx
226 West 238th Street
Bronx, NY 10463

Gramercy
7 Gramercy Park West
Lower Level
New York, NY, 10003

ThrIVewell INFUSION
Office: 212-803-3339 Fax : 646-768-8600

Mission Medical

Terrytown
555 Taxter Road
3rd Floor
Elmsford, NY 10523

Port Jefferson
12 Medical Drive
Suite B
Port Jefferson Station, NY 11776

Staten Island
27 New Dorp Lane
Staten Island, NY 10306

Southampton
625 Hampton Road
Southampton, NY 11968

Riverhead
1228 E Main Street
Suite A
Riverhead, NY 11901

Holbrook
233 Union Avenue
Suite 207
Holbrook, NY 11741

Woodbury
75 Froehlich Farm
Woodbury, NY 11797

Manhasset
333 East Shore Road
Suite 201
Manhasset, NY 11030

Rockville Centre
165 North Village Avenue
Suite 133
Rockville Center, NY 11570

5 Towns
141 Washington Avenue
Cedarhurst, NY 11559

New Hyde Park
1991 Marcus Ave
Suite 110
Lake Success, NY, 11042

(intravenous immunoglobulin)

IVIG

Iinfusion orders

Date: _____

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐NKDA Allergies:		Weight lbs/kg:

REFERRAL STATUS

☐New Referral ☐Referral Renewal ☐Medication/Order Change ☐Benefits Verification Only ☐Discontinuation Order

PHYSICIAN INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: Fax:
Practice Address:	City: State: Zip Code:

IVIG ORDERS

BRAND:

- ☐ Gamunex (10%)
- ☐ Gammagard (10%)
- ☐ Privigen (10%)
- ☐ Panzyga (10%)
- ☐ Octagam (10%)
- ☐ Gammaked (10%)
- ☐ Gammaplex (10%)
- ☐ IV _____

DIAGNOSIS *Please provide ICD-10 code*

- ☐ _____ Primary Immunodeficiency (PI)
- ☐ _____ Idiopathic Thrombocytopenic Purpura (ITP)
- ☐ _____ Multifocal Motor Neuropathy (MMN)
- ☐ _____ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
- ☐ _____ Myasthenia Gravis
- ☐ _____ Hypogammaglobulinemia

_____ _____
(other)

PRE-MEDICATION

- ☐ Tylenol 1000mg PO
- ☐ Diphenhydramine 25mg PO
- ☐ Cetirizine 10mg PO
- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP

_____ *(other)* _____ *(other)*

PATIENT WEIGHT

_____ lbs.

_____ kg

DOSAGE: Grams/Day

- ☐ _____ gm per day ☐ ONCE
- ☐ _____ gm per day DAILY x_____ days

Frequency:

- ☐ ONCE
- ☐ Eveery_____ weeks x _____weeks
- ☐ for 1 year
- ☐ Other_____

DOSAGE: Grams/Day

- ☐ _____ mg/kg over ☐ _____ days

Frequency:

- ☐ ONCE
- ☐ Eveery_____ weeks x _____weeks
- ☐ for 1 year
- ☐ Other_____

NOTES/ADDITIONAL COMMENTS:

REQUIRED DOCUMENTATION CHECKLIST:

- ☐ _____ Patient Demographics
- ☐ _____ Insurance Card/Information
- ☐ _____ Recent Labs
- ☐ _____ Recent Progress

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____

Diagnosis Code: _____
Order/dosage: _____
Signature: _____