SCIG REFERRAL FORM

FLEXCARE INFUSION CENTERS

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

• Insurance Card • H&P • Patient Dems • Most Recent Labs • Medication List • Current IG Levels

PRIMARY DIAGNOSIS

☐ D80.0 Hereditary hypogammaglobulinemia
☐ D80.9 Immunodeficiency with predominantly antibody defects, unspecified
☐ D83.9 Common variable immunodeficiency, unspecified
☐ Other:_____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

☑ Per infusion clinic protocol: No recommended standard pre-meds for SCIG
☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

Immune Globulin (subcutaneous)
☐ Cutaquig 16.5%
☐ Hyqvia 10%
☐ Xembify 20%

Dosing
☐ _____GRAMS SubQ once every _____weeks
☐ _____milligrams SubQ once every _____weeks
☐ Other:_____

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted:_____

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per FlexCare Infusion Centers' protocol
(See flexcareinfusion.com for detailed policy)
☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

Provider Signature _____ Date _____

FAX: (888) 219-8102 | EMAIL: orders@flexcareinfusion.com | VISIT: flexcareinfusion.com/referrals

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