



**MATAGORDA REGIONAL**  
 MEDICAL CENTER  
 MRMCMC IV THERAPY SERVICES  
 PHONE: 979-241-5966  
 FAX: 979-241-5965

**INTRAVENOUS IMMUNO GLOBULIN ORDER FORM**

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI \_\_\_\_\_ DOB: \_\_\_\_\_  
 HT: \_\_\_\_\_ WT: \_\_\_\_\_ Sex : ( ) Male ( ) Female SSN: \_\_\_\_\_ Home #: \_\_\_\_\_ Cell#: \_\_\_\_\_  
 Street Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
 Allergies: \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance Name \_\_\_\_\_ Policy ID #: \_\_\_\_\_  
 Secondary Insurance Name \_\_\_\_\_ Policy ID #: \_\_\_\_\_

**PHYSICIAN / FACILITY INFORMATION**

Physician Name \_\_\_\_\_ Contact Name \_\_\_\_\_ Contact Phone # \_\_\_\_\_  
 Address: \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
 DEA#: \_\_\_\_\_ NPI #: \_\_\_\_\_ State Lic #: \_\_\_\_\_ Fax #: \_\_\_\_\_

**STATEMENT OF MEDICAL NECESSITY**

Primary Diagnosis: ICD 10 + Description: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_

- a) ALL MEDIPOINTS// IV ACCESSES WILL BE ACCESSED AND FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL PROTOCOL
- b) ADMINISTER CATH-FLO 2MG, IVP PER PORT IF PICC LINE IS SLUGGISH OR OCCLUDED, MAY REPEAT AFTER 2 HRS IF NEEDED X 1

**PRESCRIPTION ORDERS: IVIG** (DOSES WILL BE ROUNDED TO NEAREST 5 GM or 10 GM INCREMENT TO ELIMINATE WASTE)

Does patient have venous access?  YES  NO

If yes, what type:  MEDIPOINT  PIV  PICC LINE  OTHER: \_\_\_\_\_

**PREFERRED BRAND** (substitution may apply): \_\_\_\_\_

SELECT BELOW	DOSE	ROUTE	RATE	REPEAT EVERY	DURATION
	MG / KG				
	GRAM / KG				
	GRAM(s) (TOTAL)				

**PREMEDICATIONS**

SELECT BELOW	MEDICATION	DOSE	ROUTE
	BENADRYL, PRN		
	ACETAMINOPHEN, PRN		
	Other:		
	Other:		
	Other:		

**LABS**

SELECT BELOW	LAB REQUESTED	WHEN	FREQUENCY
	BMP	( ) PRIOR ( ) POST	
	CMP	( ) PRIOR ( ) POST	
	BUN/CREATININE	( ) PRIOR ( ) POST	
	Other:	( ) PRIOR ( ) POST	
	Other:	( ) PRIOR ( ) POST	

**NOTES/INSTRUCTIONS/COMMENTS**

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FLUSHES:  10 mL NS Flush Syringe PRN  Heparin 500 units/5 mL Flush Syringe PRN  NS 50 mL PRN

Physician's Signature: \_\_\_\_\_ Time: \_\_\_\_\_ Date: \_\_\_\_\_

Fax completed form to the MRMCMC Infusion Center at 979-241-5965.  
 PLEASE include copies of: H+P, OFFICE NOTES, LABS, ACTIVE MEDICATION PROFILE, and CURRENT INSURANCE INFORMATION in order for your referral to be processed. Reviewed 04/2026