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Gastroenterology

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South Plains
Infusion

IVIG (Intravenous Immunoglobulin)

Name: _____

DOB: _____

M F

Phone #1 : _____ (H/W/C)

Phone #2: _____ (H/W/C)

Allergies: _____

DIAGNOSIS (ICD-10):

- D69.3 Immune Thrombocytopenic Purpura
- D80.9 Immunodeficiency with Predominantly Antibody Defects, Unspecified
- D81.9 Combined Immunodeficiency, Unspecified
- D83.9 Common Variable Immunodeficiency, Unspecified
- G61.81 Chronic Inflammatory Demyelinating Polyneuritis
- G61.82 Multifocal Motor Neuropathy
- Other: Code: _____ Description: _____

PRE-MEDICATION ORDERS

- Solu-Cortef 50-100mg SIVP PRN
- Solu-Medrol 100-125mg SIVP PRN
- Tylenol tablet 500-1000mg PO PRN
- Benadryl 25mg PO PRN
- Other: _____

IVIG ORDERS

- | DOSAGE | PATIENT WEIGHT |
|---|----------------|
| <input type="radio"/> Induction dose _____ mg/kg every _____ days | _____ lbs |
| <input type="radio"/> Maintenance dose _____ mg/kg every _____ days | _____ kg |
| <input type="radio"/> One time dose _____ mg/kg | |

NOTES

ORDERING PROVIDER

Signature X _____

Date _____

Provider _____ Phone _____ Fax _____

Please FAX: Medication Order Demographics Clinicals Labs X-Rays
to 1-806-302-1241 (must dial "1")