SOLEO HEALTH
Simplifying Complex Care

Immunology Referral Form

Please complete the following and fax with clinical documentation to:

p: 844.575.1515 | f: 877.393.1616 | e: specialtyreferrals@soleohealth.com

REFERRAL PROCESS

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

Gender: ☐ M ☐ F ☐ Nonbinary Height: Weight:

Allergies: _____

3. DIAGNOSIS Year of diagnosis: _____

Please print diagnosis and ICD10 Code:_____

4. INSURANCE INFORMATION
Please submit copies of the front and back of 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. MEDICATION ORDERS Anticipated Start Date: _____

Immune Globulin ☐ Pharmacy to select IVIG Product ☐ Specific Brand desired, please specify:_____ ☐ IV ☐ SQ
☐ SCIG pre-filled syringe option, if appropriate for patient ☐ Not applicable
Administer _____ grams daily for _____ day(s) OR _____ milligrams/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: 12.5mg 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

RN to assess, administer, and/or instruct patient/caregiver on medication, administration, vascular access device, disease process, signs or symptoms of adverse effects or complications of therapy. RN to establish, maintain and discontinue vascular access device. RN to draw labs as ordered via vascular access device or venipuncture.

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

10. ☐ Dispense as written ☐ Substitution Permitted

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