

**INTRAVENOUS IMMUNOGLOBULIN (IVIG)  
PHYSICIAN ORDER SHEET**



Verbal and telephone orders must be signed by physician on first visit to the hospital thereafter (Public Hospital Act)

**NON-MEDICATION ORDERS**

***PRE-IVIG INFUSION CHECKLIST***

Patient Weight: \_\_\_\_\_

- Immunoglobulins sent to rule out IgA deficiency
- Bloodwork

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**DRUG ALLERGIES**

List Drug	Describe Reactions/Allergies
_____	_____
_____	_____
_____	_____

No known drug reaction/allergies

**MEDICATION ORDERS**

**TIMING OF IVIG INFUSIONS**

Patient to be given the infusion regimen of IVIG as outlined below every  \_\_\_\_\_ weeks OR  \_\_\_\_\_ month(s) for a total of  \_\_\_\_\_ infusions.

**PRE-IVIG INFUSION**

- Insert IV of D5W
- Premedicate with **650 mg PO Acetaminophen (Tylenol®)** 30 minutes prior to the infusion
- Premedicate with **50 mg IV Diphenhydramine (Benadryl®)** prior to the infusion
- Other: \_\_\_\_\_

**IVIG INFUSION**

- Give **IVIG** \_\_\_\_\_ **grams IV** over \_\_\_\_\_ hours for \_\_\_\_\_ consecutive days (*Typical dose is 2.0 grams/kg given in divided doses over 2-4 days; 1.0 g/kg/day x 2 days or 0.5 g/kg/day over 4 days*)
- Diphenhydramine (Benadryl®) 50 mg IV q6h prn**
- Acetaminophen (Tylenol®) 650 mg PO q4h prn**

**POST-IVIG INFUSION**

- Furosemide (Lasix®) \_\_\_\_\_mg**  **PO** /  **IV** post IVIG (*20-40 mg*)
- D/C IV & D/C Home**
- Other: \_\_\_\_\_

PHYSICIAN'S SIGNATURE	YR.	MO.	DAY	TIME
	PHYSICIAN'S PRINTED NAME			
PHYSICIAN'S PRINTED NAME		AUTHORIZED PHYSICIAN'S SIGNATURE		