Quinte Health

AFFIX LABEL HERE

Intravenous Immune Globulin (IVIG) Out-patient Order Set

***Physician to fax completed IVIG order set and MOHLTC IVIG Request Form to:
Medical Day Clinic Belleville and Trenton – 613-961-7517 Picton – 613-476-1085 Bancroft - 613-332-6988 ***

Recommended CBC and Type and Screen completed prior to initial infusion. Results to be faxed to Blood Bank – 613-961-7511

(Receiving nurse fax completed Order set and MOHLTC Request Form to Blood Bank– 613-961-7511 for initial order or change of orders)

Clinical Indication: _____

Allergies: ☐ NKA or _____

Pre-medication

☐ No pre-medication
☐ methyl**PREDNIS**olone _____ mg IV x 1 dose
☐ diphenhydr**AMINE** 25 – 50 mg PO/IV q4h PRN
☐ dimenhy**DRINATE** 25 – 50 mg PO/IV q4h PRN (start with lower dose if elderly/frail)
☐ acetaminophen 325 – 650 mg PO q4h PRN
☐ Other: _____

IV Therapy

IV Fluid - Use D5W for required line flushing
☒ Initiate IV with D5W TKVO
☒ Discontinue IV when infusion completed

Immune Globulin

☐ Immune Globulin _____ g IV x1
☐ Immune Globulin _____ g IV given every _____ day(s) for _____ weeks **(max 26 weeks)**
☐ Immune Globulin _____ g IV given every _____ week(s) for _____ weeks **(max 26 weeks)**
☐ Other: _____

Vitals

☒ Notify physician if:

- Systolic or Diastolic BP changes greater than 20%
- Temperature changes greater than 1 degree C
- Appearance of flushing, chills, itching, uticaria and/or wheezing

Contact Blood Bank of any transfusion reactions at extension 2363

Physician/Practitioner Signature	Print Name/Designation	Date	Time

Transcribed By: _____ Designation _____ Date _____ Time _____

Checked By: _____ Designation _____ Date _____ Time _____

☐ Sent to Pharmacy Date _____ Time _____