

AMB Outpatient Immune Globulin (IVIG) Administration

*****Orders valid for 6 months only*****

Infusion of IVIG

Allergies ☐ NKA or _____

IVIG given q_____ (days/weeks/months) for _____ (days/weeks/months)

****Physician to fax completed IVIG order set and MOHLTC IVIG Request Form to:**

Medical Day Clinical Belleville & Trenton; 613-961-7517 Picton: 613-476-1085 Bancroft: 613-332-6988***

*****If CBC and Group & Screen required complete prior to initial infusion. MRP to order via outpatient lab at Quinte Health prior to IVIG appointment 613-961-7511*****

*****Receiving nurse to fax completed order set and MOHLTC Request Form to Blood Bank for initial order or Order Changes*****

Visit Admission/Transfer Discharge

☒ PowerPlan Nurse to initiate (nurse to initiate orders when patient arrives for transfusion)

☒ Verify Consent on Chart (for IVIG administration)

Vital Signs/Monitoring

☒ Vital Signs: As per Blood and Blood Products Administration Policy

IV Solutions/Infusions/IV Maintenance Therapy

☒ Saline Lock (routine, instructions: if no existing venous access device)

☒ Discontinue Saline Lock (Discontinue peripheral IV after transfusion complete)

☒ Dextrose 5% in Water intravenous solution (SOLN-IV, IV, CONTINUOUS, 5mL/hr)

Medications *Premeds should not be ordered unless recurrent allergic or febrile reactions (3 or more) OR patient is high risk for circulatory overload)

Pre-Infusion Medications

☐ acetaminophen 650 mg, PO, Tab, Administer pre-transfusion

☐ acetaminophen 1000 mg, PO, Tab, Administer pre-transfusion

☐ cetirizine 5 mg, PO/FT, Tab, Administer pre-transfusion

☐ cetirizine 10 mg, PO/FT, Tab, Administer pre-transfusion

☐ cetirizine 20 mg, PO/FT, Tab, Administer pre-transfusion

☐ diphenhydrAMINE 25 mg PO, Cap, Administer pre-transfusion

☐ diphenhydrAMINE 50 mg PO, Cap, Administer pre-transfusion

☐ diphenhydrAMINE 25 mg, IV-DIRECT/PUSH, INJ-SOLN, Administer pre-transfusion

☐ diphenhydrAMINE 50 mg IV-DIRECT/PUSH INJ-SOLN, Administer pre-transfusion

☐ hydrocortisone 100 mg IV, DIRECT/PUSH, INJ, Administer pre-transfusion

☐ furosemide 20 mg, IV-DIRECT/PUSH, Once, give immediately prior to the start of the transfusion

☐ furosemide 40 mg, IV-DIRECT/PUSH, Once, give immediately prior to the start of the transfusion

☐ furosemide 80 mg, IV-DIRECT/PUSH, Once, give immediately prior to the start of the transfusion

Physician/Practitioner Signature

Print Name/Designation

Date

Time

Transcribed By: _____ Designation _____ Date _____ Time _____

Checked By: _____ Designation _____ Date _____ Time _____

Date _____ Time _____

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Side Effect Management

- ☐ acetaminophen 650 mg, PO, TAB, q4h, PRN for transfusion reactions
- ☐ acetaminophen 1000 mg, PO, TAB, q6h, PRN for transfusion reactions
- ☐ cetirizine 5mg, PO, TAB, Administer pre-transfusion
- ☐ cetirizine 10 mg, PO, TAB, Administer pre-transfusion
- ☐ cetirizine 20 mg, PO, TAB, Administer pre-transfusion
- ☐ diphenhydrAMINE 25 mg PO,CAP, Administer pre-transfusion
- ☐ diphenhydrAMINE 50 mg PO,CAP, Administer pre-transfusion
- ☐ diphenhydrAMINE 25 mg IV-DIRECT/PUSH, INJ-SOLN, q4h, PRN for transfusion reactions
- ☐ diphenhydrAMINE 50 mg IV- DIRECT/PUSH,INJ-SOLN, q4h, PRN for transfusion reactions
- ☐ hydrocortisone 100 mg, IV-DIRECT/PUSH-INJ, q6h, PRN for transfusion reactions
- ☐ meperidine, 25 mg, IV-DIRECT/PUSH, INJ, q30min for 2 doses, PRN rigors, HIGH ALERT
- ☐ meperidine, 50 mg, IV-DIRECT/PUSH, INJ, q30min for 2 doses, PRN rigors, HIGH ALERT

Laboratory/Transfusion Medicine/Blood Bank

- ☒ Administer Blood Product: IVIG Product, Quantity/Volume Transfused _____g
- ☒ IVIG Product; **Indication** _____ (CIPD, Guillain-Barre Syndrome, Immune Thrombocytopenia, Invasive group A streptococcal fascitis, Kidney transplant, Multifocal motor neuropathy, Myasthenia gravis, other non-approved condition, Pemphigus vulgaris, Peri-solid organ transpolant, post-tranfusion purpura,primary immunodeficiency, secondary immunodeficiency, staphylococcal toxic shock)

_____ Physician/Practitioner Signature	_____ Print Name/Designation	_____ Date	_____ Time
Transcribed By: _____	Designation _____	Date _____	Time _____
Checked By: _____	Designation _____	Date _____	Time _____
Date _____	Time _____		