SPRINGSIDE INFUSION

Hyqvia

Patient information

Patient name _____ **DOB** _____

Mobile number _____ **Weight** _____ ☐ kgs ☐ lbs

Diagnosis
☐ Primary immunodeficiency (pi)
☐ Chronic inflammatory demyelinating polyneuropathy (cidp)
☐ Other _____

Allergies ☐ NKDA ☐ _____

Medication instructions

Pre-medications
☐ N/A
☐ Provider prescribed: _____

Medication order

Dose
N/A
☐ Other _____

Frequency
☐ Administer as a single day infusion
☐ Divide overtime (specify how many doses over what period of time)
☐ Other _____

Medication route
☐ Subcutaneous infusion
☐ Other _____

Lab order (Include frequency)
Please list any labs to be drawn by the infusion clinic:
☐ N/A
☐ _____

Prerequisites
Please include the following with your fax submission: Labs and tests supporting diagnosis | Office / progress notes | Demographics

Please send to ☐ Columbia, MD ☐ Silver Spring, MD ☐ Bowie, MD ☐ Frederick, MD

Referring provider information

Referring provider name _____ **NPI** _____

Practice name _____

Point of contact Name _____ Email _____ Phone _____

Provider signature _____ Date _____