PRINT

Phone: (855) 379-4250
Fax: (225) 243-7957

HaloCare
Compassionate Care, Divine Service

Immune Deficiency Referral Form

Last Name _____ First _____ DOB (mm/dd/yyyy) _____
Address _____ City _____ State, ZIP _____
Social Security # _____ Is patient age 18 or older? □ Yes □ No □ F □ M
Home Phone: _____ If no, parent/legal guardian name: _____
Cell Phone: _____ Work Phone: _____ Email: _____
Emergency contact name _____ Phone: _____

Primary Insurance Name _____ Policy # _____ Group # _____
Policy Holder Name _____ DOB _____ Insurance Phone # _____
Rx Group Number _____ Bin # _____ PCN # _____

Diagnosis: _____ ICD 10 code: _____
Cr: _____ BUN: _____ Serum Viscosity: _____ IgA: _____ Other: _____
□ NKDA Allergies: _____
□ Peripheral IV □ Central Line □ PICC □ Port a Cath □ Other: _____

□ Carimune NF □ _____ % _____ mg/kg/min _____ ml/kg/min
□ Diphehydramine □ 25mg
□ EpiPen □ 0.15mg
□ EpiPen □ 0.3mg
□ Flebogamma DIF ☐ 5%
□ Flebogamma DIF ☐ 10%
□ Gammagard Liquic ☐ 10%
□ Gammaked ☐ 10%
□ Gammaplex ☐ 5%
□ Gamunex-C ☐ 10%
□ Hizentra ☐ 20%
□ Octagam ☐ 5%
□ Privigen ☐ 10%
□ Other _____
Directions: _____
Dispense Quantity: _____ □ 1 month supply Refills: _____

Physician Name _____ NPI # _____ DEA# _____
Address _____ City/State _____ ZIP _____
Phone ( ) _____ Fax # ( ) _____ Office Contact _____
Date: _____
Physician Signature: _____ No stamps please _____

Dispense as written Substitution Allowed