

Print Patient Name (Required)				
	DOB			
Height (cm):				
Weight (kg):				
BSA (m2):				
Allergies:				

Place Patient Barcode Here

Gammagard Liquid (IVIG) Infusion					
Admit to:	Diagnosis:		Infusion Date:		
☐ Port ☐ Broviac ☐ PICC ☐ Place Peripheral IV ☐ Topical anesthetic per protocol ☐ Normal Saline/Heparin Flush per protocol					
Premedications					
☐ Acetaminophen = mg PO (max	x dose 1000 mg)	□Methylprednisolon	e = mg IV (max 1000 mg)		
☐ Diphenhydramine = mg IV or P	O (max dose 50mg)	☐ Other:			
Gammagard liquid (IVIG) gra	ms IV once				
☐ All infusions in patients < 8 years old, and all patients receiving first or second infusion: 10ml/hr X 15 min, 20ml/hr X 15 min,					
40ml/hr X15 min, 80ml/hr X 15 min, 120ml/hr until completed					
☐ All patients ≥ 8 years old after two infusions without problems: 20ml/hr X 15 min, 40ml/hr X 15 min, 80ml/hr X 15 min,					
160ml/hr until completed					
☐ Follow above ordered titrations but continue advancing untilml/hr is reached					
☐ Titration orders if different than above:					
Nursing Orders					
Weigh patient prior to infusion.					
Monitor Vital Signs at the beginning, Q15 minutes for 1 hour and then hourly, and at the end of the infusion.					
Obtain the following labs with IV or central line access prior to the start of infusion:					
□ CBC □ CMP □ BMP □ ALT □ AST □ UA □ IGG □ IGG/IGA/IGM □ Other:					
☐ Call lab results prior to starting infusion **Fax all lab results to ordering provider**					
□ Discharge once infusion completed □ Discharge 30 minutes post infusion					
PRN medications:					
☐ Ibuprofen (10 mg/kg) = mg (Max 800 mg) PO once prn mild pain/temp > 100.4 (call for fever prior to giving)					
□ Acetaminophen (15 mg/kg) =mg (max 650 mg) PO once prn mild pain/temp > 100.4 (call for fever prior to giving, must					
wait at least 4 hrs from any prior dose) Ondansetron (0.15 mg/kg) = mg (max 8 mg) IV once prn nausea					
Medications for allergic reaction (hives/itching/flushing, etc):					
If allergic reaction occurs, call ordering provider immediately and give all medications ordered below. Do not delay					
administering medications on provider response. If ordering provider does not respond in 15 minutes call a Code Blue.					
□ Diphenhydramine (1mg/kg) = mg (Max 50 mg) IV or PO once (must wait at least 4 hrs from any prior dose)					
□ Famotidine (0.5 mg/kg) = mg (max 20 mg) IV once					
☐ Methylprednisolone (2 mg/kg) = mg (max 60 mg) IV once (must wait 6 hours from any prior steroid dose)					
For Anaphylaxis (Call a Code Blue):					
\square < 10 kg: Epinephrine 1 mg/mL (0.01 mg/kg) = mg IM once					
□ 10 to < 25 kg: Epinephrine 0.15 mg auto-injector (EpiPen Jr.) IM once					
□ ≥ 25 kg: Epinephrine 0.3 mg auto-injector (EpiPen) IM once					
Orders good until this date:	Infu	sion Frequency: Date:			
Provider's Signature:		vaic	IIIIIC		

