

INTRALIPID

Patient Information

Full Name: _____ Weight: _____ lbs kg Height: _____
 DOB: _____ Allergies: NKDA _____
 Phone Number: _____
 Patient Status: New to therapy Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

Required Documentation

- Patient Demographics and Insurance Card Medication List
 Clinical/Progress Notes Supporting Dx Most recent labs

Primary Diagnosis

 ICD-10 Code (required): _____ Diagnosis: _____

Pre-Medication

- Per violet health protocol: No recommended standard pre-medications for intravenous immunoglobulin
 Other: _____
 Acetaminophen (Tylenol) PO 500mg 650mg 1000mg
 Diphenhydramine (Benadryl) 25mg 50mg PO IV
 Methylprednisolone (Solu-Medrol) IV 40mg 125mg
 Cetirizine (Zyrtec) 10 mg PO

Therapy Administration

Intralipid 20%

- Intralipid 20% 100 mL IV every _____
 Intralipid 20% 250 mL IV every _____
 Intralipid 20% 500 mL IV every _____

Other: _____

SMOFIpid 20%

- SMOFIpid 20% 20 g in 100 ml IV every _____
 SMOFIpid 20% 50 g in 250 ml IV every _____
 SMOFIpid 20% 100 g in 500 mL IV every _____

Refills:

- x 1 year Other: _____
 Order valid for one year unless otherwise stated

Nursing Orders

- RN to flush and lock VAD/CVAD per violet health protocol (see violetinfusions.com/protocol for policy)
 Administer acute infusion and anaphylaxis medications per violet health protocol (see violetinfusions.com/protocol for policy)
 RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration.
 RN to manage VAD per company protocol and administer ordered therapy per manufacturer guidelines.
 Other: Please fax alternative reaction orders, flush orders, or nursing administration orders if checking this box

Lab Orders

- CBC at each dose every _____ CRP at each dose every _____
 CMP at each dose every _____ Other: _____

Provider Information

Provider Name: _____ Office Contact Person: _____
 Referring Practice Name: _____ Phone Number: _____
 Referring Practice Address: _____ Fax Number: _____
 City, State, Zip: _____ Email: _____
 Provider NPI: _____
 Provider Signature: _____ Date: _____