

**INTRAVENOUS IMMUNOGLOBULIN (IVIg) REQUEST FOR HAEMATOLOGICAL INDICATIONS**

PLEASE FAX COMPLETED FORM TO (08) 8927 5461 After hours phone 0411 752 025 for instructions

Please follow up Urgent Orders by phone

ARCBS CONTACT (Mon - Thur 8.30am - 4.30pm, Fri 8.30am - 3pm): (08) 8927 0937 After Hours Phone 0411 752 025

MUST BE COMPLETED

PATIENT Weight = \_\_\_\_\_ kg Height = \_\_\_\_\_ cm

**DELIVERY INSTRUCTIONS**

HOSPITAL / LABORATORY RECEIVING IVIg

PH (0 )

FAX (0 )

PATIENT DETAILS OR AFFIX HOSPITAL LABEL

SURNAME

FORENAME

SEX  M  F

UR

DOB

/ /

HOSPITAL

Previous IVIg  Yes  No Please indicate date / / and response

**Consultant confirming diagnosis**

Requesting Medical Officer Name

Signature

Phone (0 )

Pager/Mobile

Fax (0 )

Date / /

Please indicate diagnosis and provide additional information as per *Criteria for the Clinical Use of Intravenous Immunoglobulin (IVIg) in Australia* (www.nba.gov.au). INCOMPLETE ORDERS MAY DELAY APPROVAL AND PROCESSING OF REQUEST.

ITP: (please tick)  Adult  Paediatric  Refractory to steroids  
 In pregnancy  Steroids contraindicated

Foeto-maternal/neonatal alloimmune thrombocytopenia: (please tick)  Maternal  Neonatal

Post transfusion purpura

Platelet Count

Detail Bleeding

Detail other treatment including steroid use

Acquired hypogammaglobulinaemia secondary to haematological malignancies: (please tick)

CLL  Multiple Myeloma  NHL

OR other relevant B-cell tumour (specify)

Recurrent or severe infection(s)  Yes  No

Detail of infection(s)

Total IgG \_\_\_\_\_ g/L Date / / 20

Clinically active bronchiectasis  Yes  No

Haemopoietic stem cell transplantation (HSCT)

Transplant date / / 20

CONSULTANT'S LETTER MAY BE ATTACHED TO PROVIDE MORE INFORMATION

**OR OTHER HAEMATOLOGICAL CONDITIONS** (please specify)

FOR NEUROLOGICAL AND IMMUNOLOGICAL INDICATIONS PLEASE USE DEDICATED FORMS

TOTAL DOSE REQUIRED

g

OR number of doses planned (eg 2 x 24g)

Dose/kg

FREQUENCY (PLEASE CIRCLE) Once Only Monthly Other (Specify )

Date Required

/ / 20

**ARCBS AUTHORISATION (ARCBS USE ONLY)**

Approved  Yes  No — Referred to JDO/ IVIg User Group for review

Not Approved

Qualifying Criteria

Met  Not met

Product

Dose

g

Frequency

Review required by

/ / 20

(Supply will be conditional on this review)

ARCBS Delegate

Designation (MO/TN/Other)

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