

PLEASE FAX COMPLETED FORM TO YOUR HOSPITAL TRANSFUSION UNIT AS FOLLOWS:

RAH: fax (08) 8222 3076 **FMC:** fax (08) 8204 3191 **CYWHS:** fax (08) 8161 6043 **TQEH:** fax (08) 8222 6685 **LMH:** fax (08) 8252 0799

Other hospitals: fax (08) 8112 1313 or **phone if urgent:** (08) 8422 1222 or **after hours** (08) 8223 6090 (for new patient approvals)

MUST BE COMPLETED

PATIENT Weight = _____ kg Height = _____ cm

PATIENT DETAILS OR AFFIX HOSPITAL LABEL

DELIVERY INSTRUCTIONS

HOSPITAL / LABORATORY RECEIVING IVIg

SURNAME _____

FORENAME _____

SEX M F

UR _____

DOB / /

HOSPITAL _____

PH (0) _____

FAX (0) _____

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 AUTHORIZATION (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)