

INTRAVENOUS IMMUNOGLOBULIN (IVIg) REQUEST FOR HAEMATOLOGICAL INDICATIONS

PLEASE FAX COMPLETED FORM TO (08) 9421 2847 or (08) 9221 1215

Please follow up Urgent Orders by phone

ARCBS CONTACT (8.30am - 4.30pm): (08) 9421 2377 After Hours Phone: (08) 9325 3030 or (08) 9325 3333

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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