

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

RAH: fax (08) 8222 3076 **FMC:** fax (08) 8204 3191 **CYWS:** 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** / /

PH (0) _____

FAX (0) _____

HOSPITAL _____

Previous IVIg Yes No Please indicate date / / and response _____

Immunologist confirming diagnosis _____

Treating Specialist _____

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.

PRIMARY IMMUNODEFICIENCY DISEASES (please tick)

- Common variable immunodeficiency
- X-linked agamma/hypogammaglobulinaemia
- Severe combined immunodeficiency
- Wiskott-Aldrich syndrome
- X-linked lymphoproliferative syndrome
- Hyper IgM syndrome
- Severe T-cell immunodeficiency

Specific antibody deficiency (please complete the following)

Frequent bacterial infections despite continuous oral antibiotic therapy for three (3) months Yes No

Impaired antibody response to **tetanus vaccine** Normal Impaired Not performed

Impaired antibody response to **Pneumovax** Normal Impaired Not performed

For all indications above please complete the following:

Total IgG _____ **IgA** _____ **IgM** _____ (g/L) **Date** / /

Chronic Suppurative Lung Disease Yes No

CONSULTANT'S LETTER MAY BE ATTACHED TO PROVIDE MORE INFORMATION

OR OTHER CONDITIONS (IMMUNE OR GENERAL) (please specify, eg Kawasaki disease)

FOR **NEUROLOGICAL** AND **HAEMATOLOGICAL** 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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