

INTRAVENOUS IMMUNOGLOBULIN (IVIg) REQUEST FOR IMMUNOLOGICAL OR GENERAL INDICATIONS

IMMUNOLOGICAL OR GENERAL 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

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)