

INTRAVENOUS IMMUNOGLOBULIN (IVIg) REQUEST FOR NEUROLOGICAL 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

Neurologist 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.

Please tick:

- Guillain Barré syndrome
- Chronic inflammatory demyelinating polyneuropathy
- Inflammatory myopathy: (please tick)
 - Dermatomyositis Polymyositis
 - Inclusion body myositis – with dysphagia
- Multifocal motor neuropathy
- Myasthenia gravis
- Lambert-Eaton myasthenic syndrome
- IgM paraproteinaemic neuropathy

CONSULTANT'S LETTER MAY BE ATTACHED TO PROVIDE MORE INFORMATION

OR OTHER NEUROLOGICAL CONDITIONS (please specify, eg Multiple sclerosis)

FOR HAEMATOLOGICAL AND IMMUNOLOGICAL INDICATIONS PLEASE USE DEDICATED FORMS

Include relevant test results, functional criteria (eg non-ambulatory) and other treatments given.

Nerve conduction study results (please attach)

Functional criteria

Co-existing use of immunosuppressive therapy Yes No

If 'YES', please specify

Immunosuppression contraindicated Yes No

Trial of plasma exchange Yes No

If 'YES', response

NEUROLOGICAL INDICATIONS

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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