

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

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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