

PLEASE FAX COMPLETED FORM TO (8.30am - 4.30pm)(07) 3838 9420 (After Hours) (07) 3838 9400

Please Telephone Urgent Orders

ARCBS CONTACT (8.30am - 4.30pm) (07) 3838 9233 After Hours On-call Medical Officer via (07) 3838 9010

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)** _____