

INTRAVENOUS IMMUNOGLOBULIN (IVIg) REQUEST FOR NEUROLOGICAL INDICATIONS

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

Please Telephone Urgent Orders

ARCBS TELEPHONE CONTACT (07) 3838 9233

(After Hours On-call Medical Officer via (07) 3838 9010)

<p>MUST BE COMPLETED</p> <p>PATIENT Weight = _____ kg Height = _____ cm</p> <p>DELIVERY INSTRUCTIONS HOSPITAL / LABORATORY RECEIVING IVIg</p> <p>_____</p> <p>PH (0) _____ FAX (0) _____</p>	<p>PATIENT DETAILS OR AFFIX HOSPITAL LABEL</p> <p>SURNAME _____</p> <p>FORENAME _____ SEX <input type="checkbox"/> M <input type="checkbox"/> F</p> <p>UR _____ DOB / /</p> <p>HOSPITAL _____</p>
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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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