

INTRAVENOUS IMMUNOGLOBULIN (IVIg) REQUEST FOR IMMUNOLOGICAL OR GENERAL INDICATIONS

IMMUNOLOGICAL OR GENERAL INDICATIONS

PLEASE FAX COMPLETED FORM TO (02) 9234 2050 or (02) 9690 0360

Please Telephone Urgent Orders

Blood Service CONTACT (8.30am - 5.00pm) 1300 478 348 After hours on-call Medical Officer 1300 478 348

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 / /

HOSPITAL _____

PH (0) _____ FAX (0) _____

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) _____