

Weekly Order Form for Regular Intravenous Immunoglobulin Patients (Landscape)

Please fax or email to: **Inventory & Distribution NSW (02) 9234 2050 or (02) 9690 0360 nswclastdistcoord@redcrossblood.org.au**

Week commencing / /20		AHP Name / Code:			Delivery date:			
					Deliver To:			
Treatment Area:		Area IVIg Contact:			Area Ph:		Fax:	
Patient name (or attach addressograph label)	D.O.B (mandatory) & MR/UR number	Product / Dose (e.g. 39g x 2 days)	Planned Tx Date(s)	Comments e.g. weight changes reason for early dose platelet count for ITP	Blood Service Use Only			
					Prod*	Dose (g)	Initials	Comments
1.	DOB: MR/UR:							
2.	DOB: MR/UR:							
3.	DOB: MR/UR:							
4.	DOB: MR/UR:							
5.	DOB: MR/UR:							
6.	DOB: MR/UR:							
<ul style="list-style-type: none"> Please note the dose and product that the Blood Service can authorise is based on current records held at the Blood Service. For any patients with significant clinical changes e.g. change of product, frequency of dose requested, weight changes, update on current status or new patients please complete the "Immunological or General, Neurological, Haematological, or Renal" indications IVIg Request Form For patients with ITP a current platelet count must be submitted. 								*Product Codes: I = Intragam F = Flebogamma O = Octagam

Enquiries Ph: 1300 478 348

Disclaimer

Any personal information in this Fax must be handled in accordance with the provisions of the Privacy Act 1988 [Cth]. The information contained in the fax may be confidential. If the person receiving it is not the intended recipient they should immediately advise the Blood Service by Fax or telephone response to the Blood Service sender and then deal with the Fax as directed by the Blood Service. The views expressed in this fax are those of the individual sender unless otherwise stated to be the views of the Blood Service. No warranties are intended as to the contents of this Fax.