



Outpatient IVIG Approval/Booking Request

Name: _____

DOB: _____

PHN: _____

Pt. Phone # _____

Page 1 of 2

Section A - Request: To be completed by ordering physician

Clinical Indication (required):

- | | |
|---|---|
| <input type="checkbox"/> Primary Immune Deficiency | <input type="checkbox"/> Myasthenia Gravis (MG) |
| <input type="checkbox"/> Secondary Immune Deficiency | <input type="checkbox"/> Dermatomyositis |
| <input type="checkbox"/> Idiopathic Thrombocytopenic Purpura (ITP) | <input type="checkbox"/> Juvenile Dermatomyositis |
| <input type="checkbox"/> Allogenic Stem Cell or Bone Marrow Transplant (BMT) | <input type="checkbox"/> Pemphig Vulgaris |
| <input type="checkbox"/> Guillain-Barré syndrome (GBS) | <input type="checkbox"/> Other (indicate diagnosis) _____ |
| <input type="checkbox"/> Multifocal Motor Neuropathy | |
| <input type="checkbox"/> Chronic Inflammatory Demyelinating Polyradiculoneuropathy (CIDP) | |

Immune deficiency patients only: IgG trough level: _____g/L Date drawn: _____

ITP patients only: Platelet count: _____X10⁹/L Date drawn: _____

Wt: _____kg Ht: _____cm

Allergies: _____ None known

Previous adverse reaction to IVIG? No Yes, describe _____

PICC/SVAD: No Yes, location _____

Medication	Medication	Medication

Relevant History:

Supplemental Infusion Orders:

Booking Information: Preferred hospital location for infusion(s): _____
Patient **not available:** Mon, Tue, Wed, Thu, Fri, Sat, Sun; Patient absences: _____

Consent for Transfusion of Blood Products:
 Accompanies this form To be signed in outpatient nursing unit
* Physician must have reviewed benefits, risks and alternatives of receiving a blood product with patient.

Physician last and first name, middle initial:	MSP Practitioner #:	Physician signature:	Date of request:
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Outpatient IVIG Approval/Booking Request

Page 2 of 2

Name: _____

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Section A – Request (continued): To be completed by ordering physician

IVIG Dose Requested:		
Frequency of infusion episodes: Every _____ weeks		
Induction /One time dose: _____ g divided over _____ day(s) (_____ g per day)		
Maintenance dose: _____ g divided over _____ day(s) (_____ g per day)		
Duration of series: <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> 12 months <input type="checkbox"/> Other, specify _____		
Physician last and first name, middle initial:	Physician phone :	MSP Practitioner #:
Physician signature:	Physician fax:	Date of request:
Ordering physician: Fax to 250-370-8190 Royal Jubilee Hospital Transfusion Medicine Laboratory	Booking and clinical staff: Please check “Approval” section for any modifications to this order prior to booking the patient or administering the IVIG. Any modifications to the order from the <u>screening physician</u> should be followed.	

Section B - Approval: To be completed by Transfusion Medicine Lab screening physician

Adjusted body weight calculator used? <input type="checkbox"/> No <input type="checkbox"/> Yes, adjusted body weight: _____ kg		
<input type="checkbox"/> Approved as requested		
<input type="checkbox"/> Not approved		
<input type="checkbox"/> Approved with the following modifications:		
Frequency of infusion episodes: Every _____ weeks		
Induction /One time dose: _____ g divided over _____ day(s) (_____ g per day)		
Maintenance dose: _____ g divided over _____ day(s) (_____ g per day)		
Duration of series: <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> 12 months <input type="checkbox"/> Other, specify _____		
Comments:		
<input type="checkbox"/> Ordering physician notified by phone. (Only required if dose modified or not approved.)		
Date of screening:	Screening physician name (please print):	Screening physician signature:

To be completed by Royal Jubilee Hospital Transfusion Medicine Lab technologist

<input type="checkbox"/> Faxed or copy sent to booking personnel	<input type="checkbox"/> Cerner updated	<input type="checkbox"/> Faxed to ordering physician
Tech initials: _____		

Section C - Booking: To be completed by booking personnel at applicable site

Location of infusions:			
Date/ Time	Date/ Time	Date/ Time	Date/ Time
Date/ Time	Date/ Time	Date/ Time	Date/ Time
Date/ Time	Date/ Time	Date/ Time	Date/ Time

ORDERING PHYSICIAN: Fax completed form (page 1 and 2) to RJH Transfusion Medicine Lab (250-370-8190)