Print Form

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Outpatient IVIG Approval/Booking Request

Name: _____

DOB: _____

PHN: _____

Pt. Phone # _____

Section A - Request: To be completed by ordering physician

Clinical Indication (required):

- ☐ Primary Immune Deficiency
- ☐ Secondary Immune Deficiency
- ☐ Idiopathic Thrombocytopenic Purpura (ITP)
- ☐ Allogenic Stem Cell or Bone Marrow Transplant (BMT)
- ☐ Guillain-Barré syndrome (GBS)
- ☐ Multifocal Motor Neuropathy
- ☐ Chronic Inflammatory Demyelinating Polyradiculoneuropathy (CIDP)
- ☐ Myasthenia Gravis (MG)
- ☐ Dermatomyositis
- ☐ Juvenile Dermatomyositis
- ☐ Pemphis Vulgaris
- ☐ Other (indicate diagnosis) _____

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

ITP patients only: Platelet count: _____$X10^9$/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:

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

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Outpatient IVIG Approval/Booking Request

Name: _____

DOB: _____

PHN: _____

Pt. Phone # _____

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: ☐ 3 months ☐ 6 months ☐ 12 months ☐ Other, specify _____

Physician last and first name, middle initial:	Physician phone :	MSP Practitioner #:
Physician signature:	Physician fax:	Date of request:

Ordering physician:	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 screening physician should be followed.
Fax to **250-370-8190** Royal Jubilee Hospital Transfusion Medicine Laboratory	

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

Adjusted body weight calculator used? ☐ No ☐ Yes, adjusted body weight: _____kg

☐ Approved as requested

☐ Not approved

☐ 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: ☐ 3 months ☐ 6 months ☐ 12 months ☐ Other, specify _____

Comments:

☐ 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

☐ Faxed or copy sent to booking personnel ☐ Cerner updated ☐ 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