Australian Red Cross BLOOD SERVICE

INTRAVENOUS IMMUNOGLOBULIN (IVIg) REQUEST FOR HAEMATOLOGICAL INDICATIONS

PLEASE FAX COMPLETED FORM TO YOUR HOSPITAL BLOOD BANK ON **RCH : 9345 5817** **RWH: 8345 2575**

Blood Bank will forward your request to ARCBS (the Blood Service) **PLEASE TELEPHONE URGENT ORDERS**

ARCBS CONTACT (24 hours) **Phone (03) 9694 0200**

MUST BE COMPLETED

PATIENT Weight = kg Height = cm

DELIVERY INSTRUCTIONS
HOSPITAL / LABORATORY RECEIVING IVIg

PH (0) **FAX** (0)

PATIENT DETAILS OR AFFIX HOSPITAL LABEL

SURNAME

FORENAME **SEX** ☐ M ☐ F

UR **DOB** / /

HOSPITAL

Previous IVIg ☐ Yes ☐ No Please indicate date / / and response

Consultant confirming diagnosis

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.

☐ **ITP:** (please tick) ☐ Adult ☐ Paediatric ☐ Refractory to steroids ☐ In pregnancy ☐ Steroids contraindicated

☐ **Foeto-maternal/neonatal alloimmune thrombocytopenia:** (please tick) ☐ Maternal ☐ Neonatal

☐ **Post transfusion purpura**

Platelet Count **Detail Bleeding**

Detail other treatment including steroid use

☐ **Acquired hypogammaglobulinaemia secondary to haematological malignancies:** (please tick)

☐ CLL ☐ Mulitiple Myeloma ☐ NHL

OR other relevant B-cell tumour (specify)

Recurrent or severe infection(s) ☐ Yes ☐ No

Detail of infection(s)

Total IgG g/L **Date** / / 20

Clinically active bronchiectasis ☐ Yes ☐ No

☐ **Haemopoietic stem cell transplantation (HSCT)**

Transplant date / / 20

CONSULTANT'S LETTER MAY BE ATTACHED TO PROVIDE MORE INFORMATION

OR OTHER HAEMATOLOGICAL CONDITIONS (please specify)

FOR **NEUROLOGICAL** AND **IMMUNOLOGICAL 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)

ARCBS-IVIG-L3-002 VIC Version:001 Date effective: 21/05/2008 Modified for OU use date 27/05/2008