Australian Red Cross BLOOD SERVICE

INTRAVENOUS IMMUNOGLOBULIN (IVIg) REQUEST FOR IMMUNOLOGICAL OR GENERAL INDICATIONS

IMMUNOLOGICAL OR GENERAL 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

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)