Australian Red Cross BLOOD SERVICE

INTRAVENOUS IMMUNOGLOBULIN (IVIg) REQUEST FOR NEUROLOGICAL 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

Neurologist 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.

Please tick:

- ☐ **Guillain Barré syndrome**
- ☐ **Chronic inflammatory demyelinating polyneuropathy**
- ☐ **Inflammatory myopathy:** (please tick)
  - ☐ Dermatomyositis ☐ Polymyositis
  - ☐ Inclusion body myositis – with dysphagia
- ☐ **Multifocal motor neuropathy**
- ☐ **Myasthenia gravis**
- ☐ **Lambert-Eaton myasthenic syndrome**
- ☐ **IgM paraproteinaemic neuropathy**

Include relevant test results, functional criteria (eg non-ambulatory) and other treatments given.

Nerve conduction study results (please attach)

Functional criteria

Co-existing use of immunosuppressive therapy ☐ Yes ☐ No

If 'YES', please specify

Immunosuppression contraindicated ☐ Yes ☐ No

Trial of plasma exchange ☐ Yes ☐ No

If 'YES', response

CONSULTANT'S LETTER MAY BE ATTACHED TO PROVIDE MORE INFORMATION

OR OTHER NEUROLOGICAL CONDITIONS (please specify, eg Multiple sclerosis)

FOR **HAEMATOLOGICAL** 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)

NEUROLOGICAL INDICATIONS