BLOOD TRANSFUSION SERVICE
Provincial Clinical Laboratory

Queen Elizabeth Hospital
Charlottetown, PEI
Phone (902) 894-2300
Fax (902) 894-2415

Prince County Hospital
Summerside, PEI
Phone (902) 438-4280
Fax (902) 438-4281

Address for Non-PEI Residents Required

Name: _____

Street: _____ Place Label Here

City: _____ Prov./State _____

Postal Code/Zip: _____

REQUEST FOR IVIG – HEMATOLOGY (Adult)

Items preceded by a **bullet** (•) are active orders. Items preceded by a **checkbox** (☐) are only to be carried out if checked

- **Any change to indication, dose, duration or frequency requires a new order**

Note: IVIG dose is calculated using the patient's DOSING BODY WEIGHT (DBW) for all indications. To obtain the DBW calculator refer to http://novascotia.ca/dhw/nspbcp/

Patient Name:	MRN:	Allergies:
• Patient's Actual Weight (kg):	• Patient Height (cm):	• Gender:
IgA Deficient Product Required: ☐ Yes ☐ No	Is this a Repeat Dose due to lack of Expected Response? ☐ Yes ☐ No	Intended Treatment Start Date (dd/mm/yyyy):
• Infuse ____ g/kg = ____ g X ____ days. If indicated, repeat this regiment q ____ days for a total of ____ treatments		

Indicated Conditions	**Prerequisites – Checkboxes must be checked/completed as appropriate. Missing information will result in delays or denial of product** **PATIENT MUST MEET THE FOLLOWING:**	**Dose**
☐ **ITP***	☐ Major bleeding & platelets less than $50x10^9$/L ***OR*** ☐ Failed to respond to steroids after 3 or more days ***OR*** ☐ To produce an increase in platelet count to a level considered safe	**Acute:** 1 g/kg/d x 2 consecutive days **Chronic:** 1-2 g/kg no more frequently than q 2 w
☐ **Pregnancy-Associated ITP***	☐ There is major bleeding ***OR*** ☐ Platelet counts fall below $10x10^9$/L anytime during pregnancy ***OR*** $10\text{-}30x10^9$/L during second or third trimester ***OR*** ☐ Rapid elevation of platelets required before delivery	1 g/kg/d x 2 consecutive days
☐ **Post Transfusion Purpura***	No prerequisites are required	1 g/kg repeated if necessary

Possibly Indicated Conditions are approved for a 3 month period only at which time a clinical outcome questionnaire must be provided for the patient to continue treatment

Possibly Indicated Conditions	**Prerequisites – Checkboxes must be completed** **PATIENT MUST MEET THE FOLLOWING:**	**Dose**
☐ **Acquired Hemophilia with Factor VIII Inhibitor***	☐ Order must be in consultation with a Hematologist Name: _____	2 g/kg divided over 2-5 days
☐ **Factor XIII Inhibitor***	☐ Order must be in consultation with a Hematologist Name:_____	2 g/kg divided over 2-5 days
☐ **Secondary Immune Deficiency**	☐ Order must be in consultation with a Hematologist Name:_____	0.4 g/kg every 3-4 weeks
☐ **Warm Autoimmune Hemolytic Anemia**	☐ Resistant to steroids and symptomatic anemia	Up to 2 g/kg

*May be considered URGENT if notified by ordering physician

PHYSICIAN'S NAME (PRINT):	**CONTACT PHONE #/REG NO.**
PHYSICIAN'S SIGNATURE:	**DATE:**

Bar Code
LAB USE ONLY

Original – Chart