BLOOD TRANSFUSION SERVICE
Provincial Clinical Laboratory

Queen Elizabeth Hospital
Charlottetown, PEI
Phone (902) 894-2300
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Prince County Hospital
Summerside, PEI
Phone (902) 438-4280
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Address for Non-PEI Residents Required

Name: _____

Street: _____ Place Label Here

City: _____ Prov./State _____

Postal Code/Zip: _____

REQUEST FOR IVIG – HEMATOLOGY (Pediatric)

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
☐ **Fetal Alloimmune Thrombocytopenia (FAIT)***	☐ Mother had previously affected pregnancy **OR** has a family history of F/NAIT ***OR*** has been found to have platelet alloantibodies ***AND*** ☐ Treatment is under the direction of a maternal fetal medicine center	1 g/kg per week throughout the pregnancy
☐ **Neonatal Alloimmune Thrombocytopenia (NAIT)***	☐ Treatment includes consultation with or is within a high-risk neonatal center	1 g/kg per day for 2 days
☐ **Hemolytic Disease of the Newborn (HDN)***	☐ Total serum bilirubin (TSB) rising despite intensive phototherapy	0.5 to 1 g/kg with repeat dosing every 12-24 hours as necessary
☐ **ITP***	☐ Platelets less than $50x10^9$/L ***AND*** either the presence of major bleeding or surgery required ***OR*** ☐ Platelets less than $20x10^9$/L ***AND*** treatment clinically indicated	0.8 to 1 g/kg Repeat if the platelet count has not increased to above $20x10^9$/L after 24-48 hours
☐ **Neonates of Mothers with ITP***	☐ Platelets less than $50x10^9$/L ***OR*** ☐ Imaging evidence of intracranial hemorrhage or other serious bleeding	1 g/kg daily for 2 days Repeat if platelet count is still less than $30x10^9$/L after 24 hours

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
☐ **Hematological Malignancy***	☐ Acquired hypogammaglobulinemia ***PLUS*** ☐ History of severe invasive or recurrent sinopulmonary infections ***OR*** ☐ Registered on a multinational protocol which requires IVIG support	0.4 to 0.6 g/kg q 3-4 weeks
☐ **Secondary Immune Deficiency***	☐ Order must be in consultation with a Pediatric Hematologist Name:_____	0.4 g/kg every 3-4 weeks

*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