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 – IMMUNOLOGY (Adult and 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**
☐ **Primary Immunodeficiency***	☐ Order must be in consultation with an Immunologist Name: _____ ***AND*** ☐ IgG levels done within last 5 months Level _____g/L date:_____ Target: 7-10 g/L for most patients May be considered urgent if acute/severe infection	**ADULT:** 0.4-0.6 g/kg every 4 weeks **PEDIATRIC:** 0.3-0.6 g/kg every 4 weeks
☐ **Secondary Immunodeficiency***	☐ Recent life threatening or recurrent clinically significant infection(s) related to low levels of polyclonal immunoglobulin May be considered urgent if acute/severe infection	**ADULT:** 0.4-0.6 g/kg every 4 weeks **PEDIATRIC:** 0.6-0.7 g/kg q 3-4 weeks

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**
☐ **Chronic Idiopathic Urticaria ADULT ONLY**	☐ Has failed to respond or has contraindications to high dose antihistamines ***AND*** ☐ Failed to respond or has contraindications to Xolair® (if covered)	**Induction:** 1 g/kg/d for 3 days **Maintenance:** 1 g/kg q 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