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
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Address for Non-PEI Residents Required

Name: _____

Street: _____ Place Label Here

City: _____ Prov./State _____

Postal Code/Zip: _____

REQUEST FOR IVIG – RHEUMATOLOGY (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
☐ **Immune-Mediated Inflammatory Myositis* ADULT ONLY**	☐ Failed to respond or contraindications to corticosteroids ***OR*** ☐ Presence of life threatening disease	2 g/kg divided over 2-5 days q 4-6 weeks. Taper when disease stable
☐ **Juvenile Dermatomyositis* PEDIATRIC ONLY**	☐ Glucocorticoids and other 2nd line agents are contraindicated ***OR*** IVIG is part of early therapy in a critically ill child ***AND*** ☐ Order must be in consultation with a Pediatric Rheumatologist Name: _____	2 g/kg every 2-4 weeks
☐ **Kawasaki Syndrome* PEDIATRIC ONLY**	No criteria are required other than a diagnosis of Kawasaki Syndrome	2 g/kg given once. If failure to respond, a 2nd dose may be given at least 24 hours later
☐ **Systemic Onset Juvenile Idiopathic Arthritis* PEDIATRIC ONLY**	☐ Is resistant to other forms of therapy ***AND*** ☐ Order must be in consultation with a Pediatric Rheumatologist Name: _____	1-2 g/kg q 2-4 weeks

The following indications are approved for one treatment.
If additional treatments are requested, a clinical outcome questionnaire must be provided to the appropriate clinical expert for consultation

Conditions	Prerequisites – Checkboxes must be completed	Dose
☐ **Catastrophic Antiphospholipid Antibody Syndrome* ADULT ONLY**	☐ Order must be in consultation with a Rheumatologist Name: _____	2 g/kg divided over 2-5 days
☐ **Adult-onset Still's Disease ADULT ONLY**	☐ Order must be in consultation with a Rheumatologist Name: _____	2 g/kg divided over 2-5 days
☐ **Sjogren's Syndrome ADULT ONLY**	☐ Order must be in consultation with a Rheumatologist Name: _____	2 g/kg divided over 2-5 days
☐ **Hematophagocytic Lympohistiocytosis* ADULT ONLY**	☐ Order must be in consultation with a Rheumatologist Name: _____	2 g/kg divided over 2-5 days

*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