BLOOD TRANSFUSION SERVICE (2021)
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 SCIG – Subcutaneous Immunoglobulin

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:
Intended Treatment Start Date (yyyy/mmm/dd):		
• SCIG _____ g/kg ordered • Patient: infuse _____ g every _____ days for _____ treatments • Transfusion Services: dispense _____ g to patient every _____ weeks 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:_____	**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	**ADULT:** 0.4-0.6 g/kg every 4 weeks **PEDIATRIC:** 0.6-0.7 g/kg q 3-4 weeks

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

Bar Code
LAB USE ONLY