Health PEI

BLOOD TRANSFUSION SERVICE 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: ______________________________

City: ______________ Prov./State ___________

Postal Code/Zip: ______________________

Allergies: ____________________________

EMERGENCY RELEASE OF IVIG - ADULT

Complete this form **in addition to** the appropriate IVIG request form. Patient must meet the prerequisites listed on the primary IVIG request form.

Only those indications listed below may be considered for emergency release.

Patient Name: __________________________ MRN: ________________ DOB: YYYY/MMM/DD

HEMATOLOGY INDICATIONS	
☐ Immune Thrombocytopenia (ITP)	☐ Factor XIII Inhibitor
☐ Pregnancy-Associated ITP	☐ Hemophagocytic Lymphohistiocytosis
☐ Post Transfusion Purpura	☐ Fetal Alloimmune Thrombocytopenia (FAIT)
☐ Acquired Hemophilia with Factor VIII Inhibitor	
NEUROLOGY INDICATIONS	
☐ Guillain-Barré Syndrome	☐ Autoimmune Encephalitis: Rasmussen's Encephalitis
☐ Myasthenia Gravis (MG)	
IMMUNOLOGY INDICATIONS	
☐ Inborn Errors of Immunity, also known as Primary Immunodeficiency	☐ Secondary Immunodeficiency
DERMATOLOGY INDICATIONS	
☐ Dermatomyositis	
RHEUMATOLOGY INDICATIONS	
☐ Immune-Mediated Inflammatory Myositis	☐ Multisystem Inflammatory Syndrome (MIS)
☐ Hematophagocytic Lympohistiocytosis	☐ Catastrophic Antiphospholipid Antibody Syndrome
INFECTIOUS DISEASE	
☐ Group A Streptococcus (GAS) Necrotizing Fasciitis or Toxic Shock Syndrome	☐ Staphylococcus Aureus Toxic Shock Syndrome (TSS)
SOLID ORGAN TRANSPLANT	
☐ Acute Antibody Mediated Rejection	☐ BK Polyomavirus (BKV)

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

SEE REVERSE FOR PEDIATRIC INDICATIONS

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EMERGENCY RELEASE OF IVIG - PEDIATRIC

Complete this form **in addition to** the appropriate IVIG request form. Patient must meet the prerequisites listed on the primary IVIG request form.

Only those indications listed below may be considered for emergency release.

Patient Name: ____________________ MRN: ____________ DOB: YYYY/MMM/DD

HEMATOLOGY INDICATIONS	
☐ Immune Thrombocytopenia (ITP)	☐ Hematological Malignancy
☐ Post CAR-T cell therapy	☐ Secondary Immune Deficiency
☐ Neonatal Alloimmune Thrombocytopenia (NAIT)	☐ Neonates of Mothers with ITP
☐ Hemolytic Disease of the Newborn (HDN)	
NEUROLOGY INDICATIONS	
☐ Guillain-Barré Syndrome	☐ Autoimmune Encephalitis: Rasmussen's Encephalitis
☐ Myasthenia Gravis (MG)	☐ Acute Disseminated Encephalomyelitis (ADEM)
IMMUNOLOGY INDICATIONS	
☐ Inborn Errors of Immunity, also known as Primary Immunodeficiency	☐ Secondary Immunodeficiency
RHEUMATOLOGY INDICATIONS	
☐ Multisystem Inflammatory Syndrome (MIS)	☐ Systemic Onset Juvenile Idiopathic Arthritis
☐ Juvenile Dermatomyositis	☐ Kawasaki Syndrome
☐ Hematophagocytic Lympohistiocytosis / Macrophage Activation Sydrome (HLH / MAS)	
INFECTIOUS DISEASE	
☐ Group A Streptococcus (GAS) Necrotizing Fasciitis or Toxic Shock Syndrome	☐ Staphylococcus Aureus Toxic Shock Syndrome (TSS)
SOLID ORGAN TRANSPLANT	
☐ Acute Antibody Mediated Rejection	☐ BK Polyomavirus (BKV)

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

SEE REVERSE FOR ADULT INDICATIONS