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: _____ **Place Label Here**

City: _____ Prov./State _____

Postal Code/Zip: _____

Allergies: _____

ORDER SET
Intravenous Immunoglobulin (IVIG) Infectious Disease − Adult and Pediatric
(less than 18 years of age)

Patient Name: _____ Patient MRN: _____ DOB: YYYY/MON/DD

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. **If** patient height **under 152.4 cm,** Dosing Body Weight equals Actual Weight. **If** patient height **over 152.4 cm,** use the DBW Calculator to obtain a clinically appropriate Dosing Body Weight. To obtain the DBW calculator, search "NS Health IVIG Dose Calculator" in an internet search engine.

Actual Weight (kg):	Height (cm):	Gender:
Dosing Body Weight (kg − see note above):	IVIG Rounded Dose (g):	

IgA Deficient Product Required: ❑ Yes ❑ No	Is this a repeat dose due to lack of expected response? ❑ Yes ❑ No	Intended Treatment Start Date (YYYY/MON/DD):

- Infuse _____ g/kg = _____ g daily for _____ days ***OR*** Infuse _____ g/kg = _____ g divided over _____ days
- If indicated, repeat this regimen every _____ 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
❑ **Group A Streptococcus (GAS) Necrotizing Fasciitis or Toxic Shock Syndrome***	❑ Must be treated with a combination therapy of antibiotics in addition to IVIG	1 g/kg on Day 1 and 0.5 g/kg/day on Days 2 and 3 **OR** 0.15 g/kg/day for 5 days
❑ **Staphylococcus Aureus Toxic Shock Syndrome (TSS)***	❑ Must be treated with a combination therapy of antibiotics in addition to IVIG	1 g/kg on Day 1 and 0.5 g/kg/day on Days 2 and 3 **OR** 0.15 g/kg/day for 5 days

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 Parvovirus Infection with Anemia**	❑ Immunocompromised patient with parvovirus B19 causing Pure Red Cell Aplasia	**Initial:** 0.4 to 1 g/kg for 5 to 10 days **Maintenance:** 0.4 g/kg every 4 weeks
❑ **Measles Post−Exposure Prophylaxis**	❑ Susceptible pregnant individuals OR immunocompromised individuals 6 months of age and older ***AND*** ❑ IVIG should only be provided within 6 days of measles exposure	0.4 g/kg given once

***May be considered URGENT if notified by ordering prescriber**

Authorized Prescriber's Signature: _____ Reg. No.: _____

Prescriber's Name: _____ Date (YYYY/MON/DD): _____ Time: _____
Print