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

Subcutaneous Immunoglobulin (SCIG) − 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):	SCIG Rounded Dose (g):	
Intended Treatment Start Date (YYYY/MON/DD):		
• SCIG _____ g/kg ordered • Patient: infuse _____ g q _____ days Repeat for _____ treatments • Transfusion Services: dispense _____ g to patient q _____ weeks for a total of _____ weeks		

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
❑ **Inborn Errors of Immunity (IEI) also known as Primary Immunodeficiency (PID)**	❑ Order must be in consultation with an Immunologist; Hematologists, General Internists or Infectious Disease Specialists may also consult for ADULT ONLY patients Name: ***AND*** ❑ IgG levels done within the last 3 to 6 months Level _____ g/L Date: _____ (YYYY/MON/DD)	**Adult and Pediatric:** 0.1 to 0.23 g/kg every week
❑ **Secondary Immunodeficiency (SID) − Immunology**	❑ Recent life−threatening or recurrent clinically significant infection(s) related to low levels of polyclonal immunoglobulin	**Adult and Pediatric:** 0.1 to 0.23 g/kg every week
❑ **Secondary Immunodeficiency (SID) − Hematology**	Order must be in consultation with a Hematologist Name:	**Adult and Pediatric:** 0.1 to 0.13 g/kg every week
❑ **Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)**	Order must be in consultation with a Neurologist Name:	**Adult:** 0.2 to 0.4 g/kg every week
❑ **Multifocal Motor Neuropathy (MMN)**	No criteria are required other than a diagnosis of MMN	**Adult:** 0.2 to 0.4 g/kg every week
❑ **Myasthenia Gravis (MG)**	As maintenance therapy for moderate to severe MG in combination with immunosuppressive agents	**Adult:** 0.2 to 0.4 g/kg every week

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

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