DIAGNOSTIC SERVICES MANITOBA
SERVICES DIAGNOSTIC MANITOBA

BBM Best Blood Manitoba

Patient Identifier:

Name: _____

PHN: _____

DOB: _____

Intravenous Immune Globulin (IVIG) Subcutaneous Immune Globulin (SCIG) Physician Request Form

INITIAL TREATMENT

Date of Completion: _____

☐ **IVIG** ☐ **SCIG**

Patient Weight (kg): _____

Patient Height (cm): _____

BMI _____ Dose must be adjusted for BMI greater than or equal to 30
http://ivig.transfusionontario.org/dose/

Dose calculator used? _____ **If no, why was it not used?** _____

☐ Single _____ g/day x _____ days, q _____weeks

☐ ___Treatments _____ g/day x _____ days, q _____weeks **Duration:** _____ **months**

IgG level/Platelet count/other test results relevant to patient condition:

Result: _____ **Date:** _____

Required: Ordering Physician (print): *(must be an approved prescriber)*

Physician's First and Last Name: _____**Specialty:**_____

License #: _____ **Physician signature:**_____ **Consulting Physician:** _____

CLINICAL INDICATION (required):

Dermatology
- ☐ Pemphigus Vulgaris

Hematology
- ☐ Hemolytic disease of the fetus and newborn
- ☐ ITP
- ☐ Neonatal alloimmune thrombocytopenia
- ☐ Post transfusion purpura

Immunology
- ☐ **Primary immune deficiency**
- ☐ Secondary immune deficiency (**Primary diagnosis:** _____)
- ☐ Limbic (immune) encephalitis
- ☐ Recurrent or serious infection

Infectious Disease
- ☐ Group A Streptococcal fasciitis
- ☐ Staphylococcal Toxic Shock

Neurology
- ☐ Chronic Inflammatory Demyelinating Polyneuropathy
- ☐ Multifocal Motor Neuropathy
- ☐ Guillain-Barré syndrome
- ☐ Myasthenia Gravis
- ☐ Lambert-Eaton Myasthenic syndrome
- ☐ Stiff person syndrome

Rheumatology
- ☐ Dermatomyositis
- ☐ Kawasaki Disease
- ☐ Polymyositis

(Other) If clinical indication does not appear on this list:

Diagnosis: _____

Infusion site:
- ☐ WRHA ☐ Northern ☐ Prairie Mountain ☐ CCMB
- ☐ Interlake-Eastern ☐ Southern ☐ Institution: _____

Changes to treatment:
- ☐ Dose changed ☐ New Patient ☐ Patient deceased

Multiple Infusion patients:
- ☐ Subcutaneous route ☐ 6 month renewal **Date:** (mm/dd/year) _____
- ☐ Treatment discontinued ☐ Recurring Patient

All requested information must be provided. The issue of product will not occur unless completed form is received.

SAP#: 331889

DIAGNOSTIC SERVICES MANITOBA
SERVICES DIAGNOSTIC MANITOBA

BBM Best Blood Manitoba

Completion of Intravenous Immune Globulin (IVIG) and Subcutaneous Immune Globulin (SCIG) Physician Request Form

This form shall accompany a Request to Release form and is required for:

1. Initial order for one time infusion.
2. Initial order for multiple infusions.
3. Follow up evaluation shall be completed after the first 6 months of treatment and then every six months for multiple infusions. Please use Follow Up form for future infusion orders.

The Physician or designate instructions for completion:

Note: Ordering Physician must be on the Approved Prescriber list which can be found on the Best Blood Manitoba website at http://bestbloodmanitoba.ca/for-clinicians/

1. Addressograph or use patient identification sticker.
2. Complete **Date of Completion**.
3. Complete the preferred IVIG formulation.
4. Document the patient's height and weight.
5. Identify the total dose per treatment and the duration of the treatment. An online adjusted body weight calculator is available at http://ivig.transfusionontario.org/dose/ or http://www.pbco.ca/IVIG Dosing Calculator.htm or see below under Dosing Guidelines.
6. Identify the **Ordering Physician**, their **Specialty** and, if a consult has occurred, the **Consulting Physician**.
7. Check the appropriate box to identify the **Clinical Indication**.
8. Check **Other** if the Clinical Indication does not appear on the list.
9. Identify the **Infusion Site** or where SCIG will be obtained.
10. Indicate if the form completion is due to **Changes to Treatment.**

Blood Bank Instructions:

1. Verify the **Ordering Physician** is on approved list of prescribers and all information is complete.
2. Return to sender if information is missing along with the Request to Release form.
3. Add patient name, PHIN, physician and date to the IVIG site specific patient log.
4. Keep copy of form in blood bank.
5. Fax Form to Blood Management Service, 204-940-3255.

Dosing Guidelines:

Dosing Weight is an adjusted body weight of obese or overweight patients used to calculate the dose of drugs for which there are recommendations specifying that the actual body weight should be adjusted for use in the dose calculations.

Dosing Weight=Ideal Body Weight (IBW) + (0.5 x (actual-IBW)).
(**Note**: **Use Actual body weight if IBW is less than actual weight)**

Ideal Body Weight (IBW) (**male)** = 50.0 kg + 2.3 kg (each inch > 5 feet)

Ideal Body Weight (IBW) (**female)** = 45.5 kg + 2.3 kg (each inch > 5 feet)