Immunoglobulin - Request Form

Patient Name _____ **Date of birth** _____

Hospital number _____ **GP postcode** _____

Gender _____ **Height** (m) _____ **Weight** (kg) _____

Date of treatment _____ **Trust/site** _____

Category: *(Please circle)* NHS Private Private to NHS Category 2 Other _____

Patient transferred from another trust? No Yes *If yes please provide date transferred & name of hospital transferred from.* **Date** _____ **Name of hospital** _____

Consultant name _____

Consultant specialty: _____

Diagnosis _____

Confidence in diagnosis: *(Please circle)* Definite Highly likely Possible

Comments including additional justification for use _____

_____

Place of treatment *(Please circle)* Home Hospital

Type of dose *(Please circle)* Replacement Immunomodulatory

Stage of treatment *(Please circle)* First treatment On-going

Route *(Please circle)* Intravenous Subcutaneous

Proposed usage *(Please circle)* Single use Long-term use

Proposed dose *(g)* _____

Proposed frequency *(weeks)* _____

Preferred product: (for PID patients only) _____

Known allergic reactions/contraindications to specific product: *(Please circle)* Yes No

If Yes - please state which product and type of reaction _____

Was plasma exchange considered? *(Please circle)* Not applicable Tried & failed
Considered but not available Considered but patient not suitable

Alternatives tried: *(Please circle)* None Cyclophosphamide Methotrexate Corticosteroids
Rituximab Ciclosporin Other _____

Other current medication: *(Please circle)* None Cyclophosphamide
Methotrexate Corticosteroids Rituximab Ciclosporin
Other _____

Prescribing/requesting doctor: *(Please circle)* **Registrar/Consultant**

Signature **Print name** **Bleep** **Date**

Panel Decision

Panel Decision: *(Please circle)* Approve Reject

Indication colour in Guidelines: (*Please circle*) **Red** **Blue** **Grey** **Black**

Patient approved for use as: (*Please circle*) Short-term use Long-term use

If rejected - please state reason _____

_____

Efficacy tracking method _____

Efficacy value at registration _____

Additional comments _____

Name of panel member **Date of decision**

Database completion

(Once information is entered onto the database please send a copy to the panel/file in patients notes)

Database unique identifier number

Date of data entry onto database **Name of person entering data**