PARTICIPATION AGREEMENT - I will -

☐ Obtain, transport and store IVIG according to instructions
☐ Arrange to carry out the infusions as instructed
☐ Keep accurate infusion notes to provide to my Ontario physician
☐ Report to the appropriate health care provider any possible adverse reactions to IVIG and seek treatment if necessary
☐ Be responsible for any expenses incurred by out of Ontario infusion of IVIG
☐ Ensure these parameters are met, or I will not receive any further IVIG

I acknowledge that IVIG for out of Ontario infusion can be withdrawn at any time if I fail to adhere to the above or to any other requirements, or if unmanageable complications of IVIG infusion therapy occur.

X
______________________________  ________________________________
Signature of patient            Date & time of signature

If applicable:

______________________________  ________________________________
Signature of Caregiver          Date

______________________________
Print Caregiver’s Name

**Caregiver: Retain a copy for your records and give one to the patient**