Request form for:

C1 Esterase Inhibitor- Home Infusion

Patients Name: Date of Birth: Hospital # Health card #

Patient Weight: kg

Ordering Physician:

Phone # FAX#

Dose: UNITS/kg= UNITS= VIALS (each vials = 500 units)

If applicable, patients should keep vials on hand

**TO BE GIVEN** (choose one)

 At time of HAE attach. *Instructions for repeat dose:*

 On a regular basis to prevent HAE attacks. FREQUENCY

**ADMINISTRATION METHOD** (choose one option)

 Self Infusion of C1 Esterase Inhibitor

 Have C1 Esterase inhibitor available to take to the nearest Emergency room

*Most convenient hospital for patient to pick up C1 Esterase inhibitor is:*

 Go to hospital.

*C1 Esterase inhibitor to be on hand at that hospital.*

**ADDITIONAL INFORMATION**

 Arrangements have been made for patient to be trained in self-administration

 Risk, benefits and alternative s of C1 Esterase Inhibitor infusion have been explained and patient is knowledgeable in both HAE management and the appropriate use of C1 Esterase Inhibitor.

 Copy of training record has been forwarded to the TM laboratory

 Informed consent has been obtained

 C1 Esterase Inhibitor letter for urgent emergency treatment

Signature of ordering Physician: Date:

(REQUEST FORM is valid for 1 year