Patient’s Name:

Date of Birth:

Health Card #

Ordering Physician:

**C1 Esterase Inhibitor Home Infusion Log**

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| Pick-up Transfusion Service:  |
| Transfusion Service Phone:  |
| C1 Inhibitor Brand Name:  |

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| **Date of****infusion****(mmm dd/yy)** | **Time of infusion** | **Area of swelling****(see legend)** | **Severity**  | **Total volume infused (mL)** | **Lot number(s)** | **Resolution of swelling** **(h = hours, m = minutes)** | **Triggering factor** | **Adverse Reaction** |
| Mild | Moderate | Severe |
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| **Product Wasted Report** |
| **Complete:**  If any vial is wasted (broken, contaminated) or expired due to patient error. Record and discard vial in sharps container. If vial has a manufacturer’s defect (broken seal, particles or cloudy solution). Record and return vial to transfusion service. |
| **Date product****picked up (mmm dd/yy)** | **Date wasted****(mmm dd/yy)** | **Lot number** | **# of vials** | **Check (🗸) one, not both** | **If wasted, indicate whether returned to Transfusion Service**  |
| **Wasted** | **Expired** |
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| **Site Legend** |
| **R** | Right |
| **L** | Left |
| **U** | Upper |
| **Lo** | Lower |
| **A** | Abdomen |
| **T** | Throat |
| **F** | Face |
| **E** | Extremity |

Patient’s Name:

Date of Birth:

Health Card #*:*

Ordering Physician:

**C1 Esterase Inhibitor Home Infusion Log**

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| Pick-up Transfusion Service:  |
| Transfusion Service Phone:  |
| C1 Inhibitor Brand Name:  |

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| **Date of****infusion****(mmm dd/yy)** | **Time of infusion** | **Area of swelling****(see legend)** | **Severity**  | **Total volume infused (mL)** | **Lot number(s)** | **Resolution of swelling** **(h = hours, m = minutes)** | **Triggering factor** | **Adverse Reaction** |
| Mild | Moderate | Severe |
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| **Date product****picked up (mmm dd/yy)** | **Date wasted****(mmm dd/yy)** | **Lot number** | **# of vials** | **Check (🗸) one, not both** | **If wasted, indicate whether returned to Transfusion Service**  |
| **Wasted** | **Expired** |
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