**Request form for:**

**Subcutaneous Immune Globulin (SCIG) Home Infusion**

Patient Name: Date of Birth:

Hospital #: Health Card Number:

Patient weight: kg

Ordering Physician: ext. Date:

Initial Request for SCIG (complete information in box below)

If this product is for training please indicate scheduled date:

□ Primary Immune Deficiency □ Secondary Immune Deficiency (primary diagnosis: )

□ Other

Currently receiving IVIG? □ YES □ NO If yes, monthly dose is: Date of last IVIG

Prescribed dose of SCIG:

\_grams per week (dose will be rounded up or down to nearest vial size)

Please supply: 1 Month CHECKLIST

3 months

Other\_

 Allergy record reviewed and updated

 SCIG information reviewed and Informed Consent Form completed

 Blood tests ordered and/or reviewed as well as health history of patient

 Training has been completed

 Documents received by the laboratory (not needed if product is for training purposes)

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Annual Renewal of SCIG (complete information in box below)

Currently receiving SCIG at a dose of

grams per week

□ Continue at same dose of

\_grams per week

□ Change to

\_grams per week (dose will be rounded up or down to nearest vial size)

Please supply: 1 month 3 months Other

CHECKLIST

 Allergy record reviewed and updated

 SCIG information reviewed and any questions / concerns addressed.

 Blood tests ordered and/or reviewed as well as health history of patient

 Consent form completed. Date:

Signature of ordering physician Send Annual Renewal to Most Responsible Person