Physician’s Order for Subcutaneous Immune Globulin (SCIG)

Date: ___________________  □ Informed consent completed  Patient’s Diagnosis: ________________

SCIG brand name: ___________________

Concentration  □ 20% = 0.2 g/mL  □ 16.5% = 0.165 g/mL  □ Other ________________

□ Option #1: Converting Intravenous Immune Globulin (IVIG) dose to SCIG dose

IVIG dosage (grams) _______ + previous treatment interval (weeks) _______ = _______ IVIG dose grams/week

IVIG dose _______ grams/week ÷ _______ grams/mL (g/mL) = _______ mL/week SCIG

□ Option #2: Ordering SCIG usual adult dosage is 0.1 g/kg/week.

Patient’s weight _______ kg x dosage 0.1 g/kg/week = _______ g/week SCIG

SCIG dosage _______ g/week ÷ _______ g/mL = _______ mL/week SCIG

□ Option #3: Weekly SCIG _______ mL/week SCIG

<table>
<thead>
<tr>
<th>Date (dd/mm/yyyy):</th>
<th>Time:</th>
<th>Prescriber Signature:</th>
<th>Printed Name and College ID:</th>
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</thead>
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SCIG Home Infusion Program Notification for Transfusion Medicine Service (TMS)

Hospital/TMS name: ____________________  TMS/Lab telephone: ____________________

This is the first notification for this patient: □ Yes  □ No  TMS/Lab fax: ____________________

This is an order change: □ Yes  □ No  Product will be required: □ every month  □ every 3 months

Product required: _______ x 5 mL vials _______ x 10 mL vials _______ x 20 mL vials _______ x _______ mL vials

________ x 40 mL vials _______ x 50 mL vials _______ x _______ mL vials _______ x _______ mL vials

Clinic RN Signature: ____________________  Order expired on (date): ____________________

SCIG Clinic will fax TMS/Lab notification of product pickup approximately two weeks before the required date.

SCIG Clinic contact: 236-332-2270 Fax: 604-582-3742

TMS Use only

Reviewed by: ____________________  Notes: ____________________

□ Patient’s TMS computer/record updated  Order expire date: ____________________