



fraserhealth

MEDICAL DAY CARE CLINIC SCIG AND C1 INH HOME INFUSION REFERRAL



Form ID: MSXX106220A

Rev: November 29, 2021

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FAX to JPOCSC MDC (604-582-3742)

PATIENT INFORMATION:

Patient's Name: _____			Gender: _____
Last	First	Middle	
Date of Birth: _____ / _____ / _____		PHN: _____	Insurance: _____
(DD/MM/YYYY)			
Address: _____			
Street	City	Province	Postal Code
Contact Method Primary: _____		Alternate: _____	

REFERRAL INFORMATION:

Priority: <input type="checkbox"/> Routine <input type="checkbox"/> Urgent Date of Referral: _____	Referring Health Care Provider: Name: _____ Title: _____ Source: _____ MSP #: _____ Phone: _____ Fax: _____
	Reason for Referral: _____ _____ Medical Reason for Urgency: _____ _____ Relevant Medical History: _____ _____
Isolation precautions <input type="checkbox"/> Airborne <input type="checkbox"/> Contact <input type="checkbox"/> Droplet	
Referral Clinic: SCIG and C1 INH Home Infusion	
Referring Health Care Provider Signature: _____ Date: _____	

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SCIG Home Infusion Medical history

Primary diagnosis:	
Secondary diagnosis:	
Please indicate the following as appropriate: <input type="checkbox"/> medical history letter(s) <input type="checkbox"/> laboratory examination results <input type="checkbox"/> current informed consent for blood transfusion	
Current IVIG dose: _____g/ _____ weeks	Name of previous SCIG product if any: _____
IgA level: _____ date: _____	Platelet count: _____ date: _____
IgG level: trough _____ date: _____ Peak _____ date: _____	
IgG subclasses (if available): _____	
Allergy:	
Medications:	
Additional comments:	
Priority level (select applicable)	
<input type="checkbox"/> 1. no venous access, adverse reactions	
<input type="checkbox"/> 2. inability to maintain stable IgG levels, difficulty traveling for infusions	
<input type="checkbox"/> 3. social: work, family, school, travel (vacation)	
<input type="checkbox"/> 4. elective	

C1 INH (Inhibitor) home infusion

Medical history

Primary diagnosis:	
Secondary diagnosis:	
Please indicate the following as appropriate: <input type="checkbox"/> medical history letter(s) <input type="checkbox"/> laboratory examination results <input type="checkbox"/> current informed consent for blood transfusion	
Have previously used C1 inhibitor product: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Name of product: Length of time on product: Adverse reactions:	
Current C1 inhibitor dose: _____u/kg Frequency: _____ or <input type="checkbox"/> as required	
C1 INH quantitative level: _____ date: _____ Normal value for laboratory: _____	
C1 INH functional level: _____ (if quantitative level not available) Normal value for laboratory: _____ date: _____	
C4 _____ date: _____	Platelet count _____ date: _____
Allergy:	
Medication:	
Additional comments:	
Priority level (select applicable)	
<input type="checkbox"/> 1. frequent/severe attacks/delay in therapy	<input type="checkbox"/> 4. adverse reaction or contraindication to other therapy
<input type="checkbox"/> 2. difficulty traveling to hospital to obtain infusion	<input type="checkbox"/> 5. social: work, family, school, travel (vacation)
<input type="checkbox"/> 3. pregnant/breast feeding	<input type="checkbox"/> 6. elective /desire greater convenience

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