fraserhealth

MEDICAL DAY CARE CLINIC SCIG AND C1 INH HOME INFUSION REFERRAL

Form ID: MSXX106220A Rev: November 29, 2021

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: ☐ **Routine** ☐ **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 ☐ **Airborne** ☐ **Contact** ☐ **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: ☐ medical history letter(s) ☐ laboratory examination results ☐ 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)*	
☐ 1. no venous access, adverse reactions	
☐ 2. inability to maintain stable IgG levels, difficulty traveling for infusions	
☐ 3. social: work, family, school, travel (vacation)	
☐ 4. elective	

C1 INH (Inhibitor) home infusion

Medical history

Primary diagnosis:	
Secondary diagnosis:	
Please indicate the following as appropriate: ☐ medical history letter(s) ☐ laboratory examination results ☐ current informed consent for blood transfusion	Have previously used C1 inhibitor product: ☐ Yes ☐ No If yes: Name of product:
Current C1 inhibitor dose: _____u/kg Frequency: _____ or ☐ as required	Length of time on product: Adverse reactions:
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)*	
☐ 1. frequent/severe attacks/delay in therapy	☐ 4. adverse reaction or contraindication to other therapy
☐ 2. difficulty traveling to hospital to obtain infusion	☐ 5. social: work, family, school, travel (vacation)
☐ 3. pregnant/breast feeding	☐ 6. elective /desire greater convenience