Ontario

MOHLTC IVIG Request Form

<u>For non-neurology use only</u>

Patient Name
Patient Hospital/Medical Record#
D.O.B.
Gender
Location
Ontario Health Insurance#

ALL FIELDS BELOW ARE MANDATORY

Date Requested: (YYYY/MM/DD)	Treating Physician:
Date Required: (YYYY/MM/DD)	Physician Specialty:
Hospital where patient will receive IG.	Physician Phone #:

Dosage Information: (Verification of dose using Dose Calculator tool is recommended)

☐ Intravenous IG (IVIG) ☐ Subcutaneous IG (SCIG)	
Patient Weight: kg Patient Height: cm BMI: **Dose must be adjusted for BMI greater than or equal to 30**	
☐ Induction/One-time dose	g/kg = Total dose of g; divided over days
☐ Maintenance dose	g/kg = Total dose of g; divided over days; every weeks; Duration: months
Dose Calculator Used? ☐ Yes ☐ No If No, why was it not used	
IgG level/Platelet count/other test results relevant to patient condition: Result: Date:	

Clinical indication for use: **Refer to Ontario IG Management Utilization Guidelines for additional indications where IG may be appropriate.**

Specialty	
Hematology	☐ Fetal/Neonatal Alloimmune Thrombocytopenia (F/NAIT)
	☐ Hemolytic Disease of the Fetus and Newborn (HDFN)
	☐ Immune Thrombocytopenia (ITP) ☐ Adult ☐ Pediatric
	☐ Post-transfusion Purpura
Dermatology	☐ Pemphigus Vulgaris (PV) and Variants
Rheumatology: Pediatric	☐ Juvenile Idiopathic Inflammatory Myopathy (J-IIM) (previously Juvenile Dermatomyositis)
	☐ Kawasaki Disease (KD)
Rheumatology: Adult	☐ Idiopathic Inflammatory Myopathy (IIM) Includes Dermatomyositis and Polymyositis
Immunology	☐ Primary Immune Deficiency (PID)
	☐ Secondary Immune Deficiency (SID)
	☐ Hematopoietic Stem Cell Transplant in primary immunodeficiencies
Solid Organ Transplant	☐ Kidney transplant from living donor to whom the patient is sensitized
	☐ Pre-transplant (Heart)
	☐ Peri-transplant (heart, lung, kidney, pancreas)
	☐ Post-transplant
Infectious Disease	☐ Invasive Group A streptococcal fasciitis with associated toxic shock
	☐ Staphylococcal Toxic Shock
***OTHER (requires approval)**	

For Transfusion Medicine Use Only

☐ Dose verified ☐ Dose adjusted to:	By (signature req'd):
☐ Confirmed with ordering physician	Date:
☐ Approved ☐ Denied	Date:
Signature of Approving Physician:	

Please fax/send to: