Interior Health

Name: _____
Date of Birth: _____
PHN: _____
(or client label)

Subcutaneous Immune Globulin (SCIG)
Home Infusion Log

Instructions: Please attach product lot sticker from the vial to this form and record any adverse reactions as instructed.
Mail the completed forms to the address on the bottom of the form.
If you have any concerns contact your physician or the SCIG nurse at 250-469-7070 Extension 12105.

Date of infusion (mmm dd/yy)	Length of infusion (h = hours, m = minutes)	Site(s) used (see legend)	Volume per site (mL)	Total volume infused (mL)	Lot number(s)	Adverse reaction? (Yes/No) If yes, describe	List any medication(s) taken during infusion	Recent infection ? (Yes/No) Fever (°C)

Site Legend	
R	Right side
L	Left side
UA	Upper Abdomen
LA	Lower Abdomen
T	Thigh

Product Wasted Report

Record any vial that is wasted (broken, contaminated) or expired due to patient error. Discard vial in sharps container. If vial has a manufacturer's defect (broken seal, particles or cloudy solution), record and return vial to transfusion service.

Date product picked up (mmm dd/yy)	Date wasted (mmm dd/yy)	Lot number	# of vials	Check (✓) one, not both		If wasted, indicate whether returned to Transfusion Service
				Wasted	Expired	

Mail completed forms to: ATTN: Interior Health SCIG Program
Kelowna Community Health and Service Center
505 Doyle Ave
Kelowna, BC V1Y 0C5

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