Interior Health

Patient's Name::_____
Date of Birth: _____
Medical Record Number: _____
PHN: _____

Subcutaneous Immune Globulin (SCIG)
Home Infusion Program

Physician Order Form

Complete Section A B **or** C
Fax to the number indicated in Part A, B or C

Date: _____

SECTION A: New Client Orders: (must accompany Program Referral form) **Fax to Transfusion Medicine 250-862-4051**

Order: Subcutaneous Immune Globulin SCIG _____ _____ mL per week
(product) *(dose)*

Worksheet: *(if needed to determine transition from IVIG to 20% solution of SCIG)*

IVIG dosage (grams) _____÷ previous treatment interval (weeks) _____ = _____IVIG dose grams/week

IVIG dose _____ grams/week ÷ 0.2 grams/mL (g/mL) = _____ mL/week SCIG

Patient's Weight _____kg x dosage 0.1grams/kg/week =_____ grams/week SCIG

SCIG Dosage _____ grams/week ÷ 0.2 grams/mL =_____ mL/week SCIG

Physician Signature: _____ **MSP or CPSID #**: _____

SECTION B: Annual Review Orders (Include signed and dated Appreciable Risk Form # 826034 **Fax to SCIG Nurse 250-980-1505**

Order: Subcutaneous Immune Globulin SCIG)_____ _____ mL per week
(product) *(dose)*

Physician Signature: _____ **MSP or CPSID #**: _____

SECTION C: Dosage Change Orders **Fax to SCIG Nurse 250-980-1505**

Order: Subcutaneous Immune Globulin SCIG)_____ _____ mL per week
(product) *(dose)*

Physician Signature: _____ **MSP or CPSID #**: _____