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TREATMENT SUMMARY FOR PATIENTS on Immunoglobulin Therapy

Patient name: _____ UR/MRN/NHI: _____

Date of birth: _____

Contact details (phone and email): _____

Plan prepared by (date): _____

Nurse Specialist: _____

Immunology Specialist: _____

Clinical indication: _____

Next of kin (name and contact number/s: _____

Relationship to patient: _____

CURRENT ☐ IVIG OR ☐ SCIG

IVIg or SCIg product name: _____

Dose: _____ Frequency: _____

Patient weight (date): _____ Trough IgG levels (date): _____

Current problems and comments: _____

SCIG DELIVERY METHOD: ☐ RAPID PUSH OR ☐ PUMP

Giving set/needle type: _____ Needle gauge: _____ Needle length (mm): _____

Number of sites per infusion: _____ Infusion site/s: _____

Pump brand (if applicable): _____

Date SCIg technique last assessed and comments: _____

ATTACHMENTS

☐ IVIg: Product/s used: _____

Side effects, reasons for change, comments: _____

_____

☐ SCIg: Product/s used: _____

Side effects, reasons for change, comments: _____