**Southwest Peninsula Immunoglobulin Advisory Panel: Long Term Form 2 (Replacement)**

***Are you making this application of immunoglobulin for Replacement Yes***[ ]  ***No*** [ ]

***If no please use form 3 (Immunomodulation)***

This form must be signed by the consultant who will be responsible for the treatment. Please note that the Panel may be unable to reach a decision if inadequate information is provided.

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| **Has this patient met the Selection Criteria as prescribed in the DH Clinical Guidelines Yes**[ ]  **No** [ ] [**http://igd.mdsas.com/wp-content/uploads/Ig-PWG-Guidance-for-the-use-of-Ig-V1.3-12022019.pdf**](http://igd.mdsas.com/wp-content/uploads/Ig-PWG-Guidance-for-the-use-of-Ig-V1.3-12022019.pdf) |
| Panel Ref: *IAP to insert* | NHS No: | DOB: |
| Patient Name: | Trust ID Hosp no: |
| GP Details: |  |
| Height: | Weight: | Date Weighted: | M [ ]  F [ ]  |
| Consultant Name: | Speciality: | Trust /Site: |
| Consultant Email:  | Contact No: Bleep No: |
| **Proposed start date of treatment:***ongoing treatment for established follow up patients don’t need the start date.* | **Where does patient attend for treatment:***i.e.**Trust/Unit or Community hosp* |
| Pt transferred from another Trust: | Yes[ ]  No [ ]  *If yes please provide date transferred & name of hospital transferred from*. |
| Date:  | Name of Hospital:  | NHS [ ]  | Private [ ]  |
| ***NB: This will be anonymised before transmission outside clinical service*** |

***Section 1: Clinical Details:***

|  |  |
| --- | --- |
| Diagnosis: |   |
| Primary antibody deficiency [ ]  Secondary antibody deficiency [ ]  |
| Confidence in diagnosis:  | Definite [ ]  | Highly Likely [ ]  | Possible [ ]  |
| Immunoglobulin levels - Date of test:  | IgG:  | IgM: | IgA: |
| Immunisation responses: |
| Pneumococcal serotypes  | Pre imm: | Post imm: | Date given: Vaccine use:  |
| Tetanus  | Pre imm: | Post imm: | Date given:  |
| Other |  |  |  |

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| **Indication for IVIg:** *Please refer to guidelines*[**http://igd.mdsas.com/wp-content/uploads/Ig-PWG-Guidance-for-the-use-of-Ig-V1.3-12022019.pdf**](http://igd.mdsas.com/wp-content/uploads/Ig-PWG-Guidance-for-the-use-of-Ig-V1.3-12022019.pdf) |

|  |  |
| --- | --- |
| **Current Treatment**  | **Please specify drugs used** |
| None [ ]  |  |
| Rescue antibiotics [ ]  |   |
| Prophylactic antibiotic [ ]  |  |
| Other:[ ]  |  |

**Section 2: Previous response to prophylactic antibiotics**

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| --- | --- | --- | --- |
| Dates: mm/yyyy | Antibiotic used | Duration for prophylaxis | Response to treatment/infection frequency |
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| **What immunoglobulin treatment plan do you propose to follow? This must include;**1. Dosage: based on ideal body weight e.g. Ontario calculator [Ideal Body Weight (IBW) Calculator with IVIg Dosing](http://ivig.transfusionontario.org/dose/)
2. Proposed dosing schedule.
3. How do you intend to confirm on going need for Ig – please refer back to the guidelines
 |
|  |  *g Over days*  |
|  | *Frequency:* |
|  |  |

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| --- | --- | --- |
| Stage of treatment:  New [ ]  Established [ ]  | Product:  | Treatment route: Intravenous [ ]  Sub-cutaneous [ ]  |
| Place of treatment: Home [ ]  Hospital [ ]  | Has the patient been offered home care: Yes [ ]  No [ ]  |
| Is the patient receiving treatment on homecare: |
| Yes - offered accepted [ ]  | No – not offered [ ]  | No – offered declined [ ]   | Product not available [ ]  |
| Has homecare training been delivered in an accredited centre: Yes [ ]  No [ ]  N/A (Hosp therapy) [ ]  |

**For Initial application please sign and forward to email address as indicated in section 4.**

**Section 3: At point of yearly review** - *Please note efficacy will need to be demonstrated by outcome measures – reimbursement is dependent on pre & post outcome measures.*

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| **Has the patient’s condition improved since starting treatment?** Yes [ ] No [ ]  Stable [ ]  |

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| --- | --- | --- | --- | --- | --- | --- |
| Outcome 1: *e.g. infection frequency* | *Date:* | Baseline Value |  | *Date:* | Post Treatment |  |
| Outcome 2: *IgG level*  | *Date:* | Baseline Value |  | *Date:* | Trough level  |  |
| Outcome 3: | *Date:* | Baseline Value |  | *Date:* | On Treatment |  |

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| **Follow up details for patients on established treatment**  |
| Date of follow up : | Type of review : Annual review [ ]  Ongoing review [ ]  |
| Adverse reactions since last follow up:None [ ]  mild [ ]  moderate [ ]  severe [ ]  |
| Outcome of Follow-Up: Patient Died [ ]  Patient No Longer Seen [ ]  Continuing Treatment [ ]  Unknown [ ]  Treatment Complete (successful) [ ]  Treatment Complete (not successful) [ ]  Transferred to Another Trust [ ]  |
| Date patient last reviewed in Clinic: Has the GP been notified of this follow-up: Yes [ ]  No [ ]   |

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| Please describe measures that have been undertaken in the last year to review dosage and/or frequency. See guidelines for advise on this. [**http://igd.mdsas.com/wp-content/uploads/Ig-PWG-Guidance-for-the-use-of-Ig-V1.3-12022019.pdf**](http://igd.mdsas.com/wp-content/uploads/Ig-PWG-Guidance-for-the-use-of-Ig-V1.3-12022019.pdf) |
|  |

**Section 4:**

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| Prepared by signature |
| Print Name: | Trust: | Date: |

**Please return completed form to:**

Hospital Transfusion Team electronically to rde-tr.HTT@nhs.net

**Section 5:** *Panel use*

|  |
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| Panel Date:  |
| Panel Decision: Approve [ ]  Reject [ ]  |
| If reject please give details: |