**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:***

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| 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) |

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| **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) |
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**Section 4:**

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

**Please return completed form to:**

Hospital Transfusion Team electronically to [rde-tr.HTT@nhs.net](mailto:rde-tr.HTT@nhs.net)

**Section 5:** *Panel use*

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