|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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: *Panel to insert* | | | | NHS No: | | | | | | DOB: | | | | |
| Patient Name: | | | | | | | | Trust ID Hosp no: | | | | | | |
| Height: | | | Weight: | | | | | Date Weighed: | | | | | | M  F |
| Consultant Name: | | | | | Speciality: | | | | | | Trust /Site: | | | |
| Consultant Email: | | | | | | | | Dates of proposed /actual treatment: | | | | | | |
| GP Details: |  | | | | | |  | | | | |  | | |
| 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***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Diagnosis**: |  | | | |
| Confidence in diagnosis: | | Definite | Highly Likely | Possible |

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| --- | --- | --- | --- | --- | --- |
| **Current Treatment** | | | | | |
| None | Cyclophosphamide | | | Methotrexate | Corticosteroids |
| Rituximab | Ciclosporin | | | Other: | |
| **Alternatives Tried** | | | | | |
| None | Cyclophosphamide | | | Methotrexate | Corticosteroids |
| Rituximab | Ciclosporin | | | Other: Romiplostim | |
| **Has plasma exchanged been considered** | | | | | |
| Not applicable | | \*Tried & failed | Considered, not available | | \*Considered but patient not suitable |
| \*Please explain: | | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Is this first ever treatment | Yes  No | | If No - date of last treatment: | |
| Type of treatment | Immunomodulatory | | | Replacement |
| Proposed dose and schedule | | g /kg Over days | | |

|  |
| --- |
| **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> |

|  |  |  |  |
| --- | --- | --- | --- |
| **Outcome Measures to assess efficacy** | | | |
| **Supply or funding of** **Immunoglobulin may be refused if baseline measures are not completed, 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) | | | |
| Outcome 1 |  | Baseline Value |  |
| Outcome 2 |  | Baseline Value |  |
| Outcome 3 |  | Baseline Value |  |

**Prescribing/requesting doctor: Registrar  Consultant**

**Has the named consultant authorised this application Yes  No**

**Signature Print name: Bleep: Date:**

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

Please return form to:

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