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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: *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***

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| **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:  |

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| 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  |

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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> |

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| **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** [x]  **Consultant** [ ]

**Has the named consultant authorised this application Yes** [x]  **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