

INTRAVENOUS IMMUNE GLOBULIN (IVIG) OUTCOME QUESTIONNAIRE

Patient Name _____
 Date of Birth _____
 PHN _____
 Hospital Medical Record Number _____
 Ordering Physician _____

Instructions for Ordering Physician

Please answer the following questions regarding your patient who has recently completed a course of IVIG therapy.
This evaluation form must be completed in order for patient to continue receiving IVIG.

Please send the completed outcome questionnaire to the IH IVIG Coordinator.
 Fax: 250-862-4052 or Scan: IHLabIVIG@interiorhealth.ca if able to send from an IH email address.

Date _____

Name of person completing form _____

Phone _____

1. Was the desired clinical outcome achieved?

☐ Yes ☐ No

Comments _____

2. Is the minimal effective dose of IVIG being prescribed?

☐ Yes ☐ No

Comments _____

3. Were any complications associated with the IVIG therapy?

☐ Yes ☐ No

If yes, please list/describe the complication(s) _____

4. For Neuromuscular Neurology Approved Conditions (GBS, CIDP, MMN, and MG), when was the last neurological assessment?

Date: _____

Comments _____

For Transfusion Medicine Service Use Only

Reviewed by: _____

 TMS Physician

 Date

Notes _____