Interior Health

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