SCHHS Subcutaneous Immunoglobulin (SCIg) Program

Patient Assessment Form

Affix Patient Identification Label here

Assessment to be undertaken at each training session / product collection booking.

IgG blood testing is to be undertaken Pre, 2nd monthly for the first 6 months then as directed by MO.

Date Infused / collected	**Patient Assessment**
Date range __/__/__ to __/__/__	**IgG result**_____ Date of collection_____ Lab_____ **Site reaction**: no ☐ yes ☐ size_____(cm) *(please circle) redness* swelling itchy other _____ Other reactions: _____ *Since the last patient review / assessment:* **Has the patient had any recent infections** No ☐ Yes ☐ If yes: Type_____Duration_____ Did the infection require the patient to attend a GP No ☐ Yes ☐ Did the patient commence on antibiotics No ☐ Yes ☐ If yes, Name_____ Dose_____ Duration_____ Did the patient require admission into hospital No ☐ Yes ☐ If yes, how many days _____ Hospital Name_____ **Other issues** (please comment): _____ _____

Date Infused / collected Date range __/__/__ to __/__/__	**Patient Assessment** **IgG result**_____ Date of collection_____ Lab_____ **Site reaction**: no ☐ yes ☐ size_____(cm) *(Please circle) redness* swelling itchy other _____ Other reactions: _____ *Since the last patient review / assessment:* **Has the patient had any recent infections** No ☐ Yes ☐ If yes: Type_____Duration_____ Did the infection require the patient to attend a GP No ☐ Yes ☐ Did the patient commence on antibiotics No ☐ Yes ☐ If yes, Name_____ Dose_____ Duration_____ Did the patient require admission into hospital No ☐ Yes ☐ If yes, how many days _____ Hospital Name_____ **Other issues** (please comment): _____ _____

Document adverse events (including symptoms, investigations, interventions and outcomes), *not expected* with SCIg Infusion, in the patient clinical record. Notify MO, Transfusion CNC, blood bank and product company.