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- baseline, monthly for 3 months , then every 6 months.

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):

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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 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): _____ _____
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): _____ _____

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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.

Forward completed form to SCIg program co-ordinator – Transfusion CNC janine.englis@health.qld.gov.au