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TREATMENT PLAN Subcutaneous Immunoglobulin (SCIg)

Patient Name: ______________________________

Plan prepared by: ______________________________

Date: ______________________________

Note: This plan has been developed as a medical document to completed by an immunology or nurse specialist

IMMUNOLOGY AND NURSE SPECIALIST DETAILS

Immunology Specialist: ______________________________

Nurse Specialist: ______________________________

Telephone: ______________________________

Email: ______________________________

After hours contact name: ______________________________

Telephone: ______________________________

SCIG PRODUCT DETAILS

Brand: ______________________________

Dose:

1. ____________ grams ____________ mls ____________ times/week

2. ____________ grams ____________ mls ____________ times/week

To order SCIg:

Telephone: ______________________________

Email: ______________________________

To collect SCIg:

Telephone: ______________________________

EQUIPMENT

For ordering of consumable equipment supplies (e.g. syringes, needles):

Telephone: ______________________________

Email: ______________________________

For servicing of pump (if applicable):

Telephone: ______________________________

Important:

Allow 7 days when ringing to order SCIg and allow ______ days for ordering consumable equipment supplies

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