**IAP Assessment Form Immunoglobulin Replacement Therapy:**

For **new** therapy or **review** of existing therapy

**Complete all relevant patient details. Incomplete forms will be rejected and funding for immunoglobulin may be in jeopardy.**

**Once complete, submit to** [**add-tr.iap-eastofengland@nhs.net**](mailto:add-tr.iap-eastofengland@nhs.net)

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| **The Immunology specialist assessment panel meets weekly.**  **Details from:** [**ivig-coordinator@addenbrookes.nhs.uk**](mailto:ivig-coordinator@addenbrookes.nhs.uk) |

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| **Demographic details:** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of requesting Trust: | | | | | | | | Choose an item. | | | | | | | | | | | | | | | | | |
| Patient Initials: | | | | | | | |  | | | | | | | DOB: | | | | | | | | | Click here to enter text. | |
| NHS number (essential): | | | | | | | |  | | | | | | | Height (cm) | | | | | | | | | Click here to enter text. | |
| Local hospital #: | | | | | | | |  | | | | | | | Weight (kg) | | | | | | | | | Click here to enter text. | |
| If commenced / recommended by another SRIAP or immunology centre, detail below: | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Immunological diagnosis** *(please indicate if primary or secondary and give details)* | | | | | | | | | | | | | | | | | | | | | | | | | |
| Select immunodeficiency type  Choose an item. | | | | | | | | | | Primary | | | Details: | | | | | | | | | | | | |
| Secondary | | |
| Specific | | |
| If secondary details of current medication/treatment that can cause immunosuppression | | | | | | | | | |  | | |  | | | | | | | | | | | | |
| Immunoglobulin replacement commenced Y/N | | | | | | | | | | Yes | | | If yes, date commenced | | | | | | | | | | | | |
| No | | |
| Immunoglobulin product  (if commenced) | | | | | | | | | | Brand | | | If established | | | | | | | | | | | | |
| Dose | | |  | | | | | | grams | | | | | | |
| Frequency | | | Every | | | | | | | | | | | | |
| Route | | | SC or IV | | | | | | | | | | | | |
| **Co-morbidities** *(please add extra lines if required)* | | | | | | | | | | | | | | | | | | | | | | | | | |
| Bronchiectasis | | | | | | Y/N | | | Additional Co-morbidities – include below; | | | | | | | | | | | | | | | | |
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| Is the patient under the care of a respiratory physician? | | | | | | | | | | | | | | | | | Y/N | | |  | | | | | |
| Respiratory Physician’s name and Trust: | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Immunoglobulin levels Pre Commencing Immunoglobulin Therapy** | | | | | | | | | | | | | | | | | | | | | | | | | |
| IgG | | Result |  | | | | | | | | | | | | | | Date | | | | | | | Click here to enter a date. | |
| IgA | | Result |  | | | | | | | | | | | | | | Date | | | | | | | Click here to enter a date. | |
| IgM | | Result |  | | | | | | | | | | | | | | Date | | | | | | | Click here to enter a date. | |
| **Immunoglobulin level results (most recent)** | | | | | | | | | | | | | | | | | | | | | | | | | |
| IgG | Result | | |  | | | | | | | | | | | | | Date | | | | | | | Click here to enter a date. | |
| IgA | Result | | |  | | | | | | | | | | | | | Date | | | | | | | Click here to enter a date. | |
| IgM | Result | | |  | | | | | | | | | | | | | Date | | | | | | | Click here to enter a date. | |
| **Immunisation history:** | | | | | | | | | | | | | | | | | Pre-vaccination levels | | | | | | | Post vaccination levels | |
| *Haemophilus influenzae type B* | | | | | | | | | | | | | | | | |  | | | | | | |  | |
| Serotype specific pneumococcal (number of serotypes >0.35) | | | | | | | | | | | | | | | | |  | | | | | | |  | |
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| **Infection/treatment history** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Antibiotic prophylaxis (AbP) | | | | | | | | | | | Y/N | | | | | | | If Y, start date: | | | | | | | |
| Please give details of antibiotic and dose | | | | | | | | | | | | | | | | | | | | | | | | | |
| Allergies to antibiotics | | | | | | | Y/N | | | | | If Y please list: | | | | | | | |  | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
| History in last 12 months | | | | | | | | | | |  | | | | | | | | | | |  | | | |
| Total number | | | | | | | | | | | Number while on AbP | | | |
| Chest infections | | | | | | | | | | |  | | | | | | | | | | |  | | | |
| Radiologically proven pneumonia | | | | | | | | | | |  | | | | | | | | | | |  | | | |
| Sinus/URT/ear infections | | | | | | | | | | |  | | | | | | | | | | |  | | | |
| Courses of antibiotics | | | | | | | | | | | Oral | | | | | IV | | | | | Oral | | | | IV |
| Hospital admissions with infection | | | | | | | | | | |  | | | | | | | | | | | | | | |
| Details of other significant infections | | | | | | | | | | |  | | | | | | | | | | | | | | |
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| Microbiology /Organisms identified *(please add extra lines if required)* | | | | | | | | | | | | | | | | | | | | | | | | | |
| Organism (e.g. *Haemophilus influenzae*) | | | | | | | | | | | | | | Sample/Site (e.g. Sputum/BAL) | | | | | | | | | | | |
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| **Referring clinician** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name | | | | | | | | |  | | | | | | | | | | | | | | | | |
| Hospital | | | | | | | | |  | | | | | | | | | | | | | | | | |
| NHS e-mail address\* | | | | | | | | |  | | | | | | | | | | | | | | | | |
| Contact telephone number | | | | | | | | |  | | | | | | | | | | | | | | | | |
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| **Immunology MDT** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Submitted (date) | | | | | | | | | | | | | | | | | | | | | | | Click here to enter a date. | | |
| Reviewed at (date of meeting) | | | | | | | | | | | | | | | | | | | | | | | Click here to enter a date. | | |
| Outcome: | | | | | | | | | | | | | | | | | | | | | | | Click here to enter a date. | | |
| Communication to: | | | | |  | | | | | | | | | | | | | | | | | | | | |