**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**

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

|  |
| --- |
| **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: |
|  |
|  |
| **Immunological diagnosis** *(please indicate if primary or secondary and give details)* |
| Select immunodeficiency typeChoose 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; |
|  |
| 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) |  |  |
|  |  |
| **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 |  |
|  |
|  |
| Microbiology /Organisms identified *(please add extra lines if required)* |
| Organism (e.g. *Haemophilus influenzae*) | Sample/Site (e.g. Sputum/BAL) |
|  |  |
|  |  |
|  |
| **Referring clinician** |
| Name |  |
| Hospital |  |
| NHS e-mail address\* |  |
| Contact telephone number |  |
|  |
| **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: |  |