ALBERTA PRECISION LABORATORIES

Leaders in Laboratory Medicine

Shaded areas are required information.

Subcutaneous Immune Globulin
Product Order and Home Use Dispense Requisition

ORDERING PHYSICIAN					
PROVIDER CC ID					
TELEPHONE NUMBER:	**FAX NUMBER:**				
ORDER DATE	**ORDER TIME**				
DOSE IN MLS PER WEEK	**NUMBER OF WEEKS REQUESTED**	PATIENT DIAGNOSIS	PATIENT WEIGHT (Kg)	PATIENT HEIGHT (CM)	**FORM COMPLETED BY (NAME):**

Affix addressograph imprint or patient label or clearly **print** patient's full name (last name, full first name), date of birth, gender, Personal Health Number, Medical Record Number

Request for Dispense of Hizentra:	**Request for Dispense of Cuvitru:**
_____ vials of 5 mL (1 g IgG)	_____ vials of 5 mL (1 g IgG)
_____ vials of 10 mL (2 g IgG)	_____ vials of 10 mL (2 g IgG)
_____ vials of 20 mL (4 g IgG)	_____ vials of 20 mL (4 g IgG)
_____ vials of 50 mL (10 g IgG)	_____ vials of 40 mL (8 g IgG)

Patient information for pick up of product

Pick up date: _____

Pick up location:

- ☐ ACH
- ☐ FMC
- ☐ PLC
- ☐ RGH
- ☐ SHC
- ☐ Other: _____

For TM use only	
Place dispense portion of tag here	Place dispense portion of tag here

Fax completed form to FMC transfusion Medicine at 403-270-7205.
As per AHS policy, all faxes must include a coversheet.