

 ALBERTA PRECISION LABORATORIES Leaders in Laboratory Medicine	Shaded areas are required information.	Subcutaneous Immune Globulin Product Order and Home Use Dispense Requisition			
	ORDERING PHYSICIAN		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		
TELEPHONE NUMBER:	FAX NUMBER:				
ORDER DATE	ORDER TIME				
DOSE IN MLS PER WEEK	NUMBER OF WEEKS REQUESTED	PATIENT DIAGNOSIS			

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)

<p>Patient information for pick up of product</p> <p>Pick up date: _____</p> <p>Pick up location:</p> <p><input type="checkbox"/> ACH</p> <p><input type="checkbox"/> FMC</p> <p><input type="checkbox"/> PLC</p> <p><input type="checkbox"/> RGH</p> <p><input type="checkbox"/> SHC</p> <p><input type="checkbox"/> Other: _____</p>

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.**