Ontario Immunoglobulin Treatment Program

Patient Demographics Sticker Here or
Name
DOB
Address

Phone

Health Card #

SAH Ontario Immunoglobulin Treatment Program Referral Form

Please Fax Referral Form: 705-759-3841

Date: _____ **Diagnosis**_____

Requesting the following IG: SICIG ☐ **IVIG** ☐ Height: _____ Weight:_____

Previous IG treatments or other related treatments? _____

_____

Any Pre-Infusion PRN Medication Protocol?

_____

_____

Special Instructions: _____

_____

_____

Please include last progress note and vaccine record if available.

Provider Name: _____ **Provider Signature:** _____

Phone: _____ **Fax:** _____ **Email:** _____

SAULT AREA HOSPITAL
HÔPITAL DE SAULT-SAINTE-MARIE

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Health Records – Do Not Destroy