



My Hizentra® Therapy Log Sheet

Name: _____

Date of Birth: _____

Treating Physician: _____

Blood Bank/Pharmacy Name: _____

Blood Bank/Pharmacy Phone: _____

Infusion date (yyyy/mm/dd)	Duration of infusion (h=hours, m=minutes)	Site(s) used (see legend)	Volume/ site (mL)	Total volume infused (mL)	Lot number(s) infused	List any side effects*	List any medication(s) taken during infusion

SITE LEGEND

R Right
L Left
U Upper
Lo Lower
A Abdomen
H Hips
Leg Leg/thigh

Hizentra® Waste Report

Record any wasted (broken, contaminated) or expired vials/pre-filled syringes in the table below. Follow your healthcare professional or blood bank/pharmacy instructions on product wastage. If the vial/pre-filled syringe has a manufacturer's defect (broken seal, particles or cloudy solution), record below and return to blood bank.

Date (yyyy/mm/dd)	Lot number	# of vials/ pre-filled syringes	Reason for waste

* To report adverse events, please refer to the instructions on Reporting Suspected Side Effects included in the Consumer Information Leaflet provided with your Hizentra® vial and/or pre-filled syringe.