Rh PROGRAM of NOVA SCOTIA

5850 /5980 University Avenue, PO Box 9700
Halifax, Nova Scotia, Canada, B3K 6R8
Tel (902) 470-6458 Website: http://rcp.nshealth.ca/rh

ORDER for Rho(D) immune globulin (WinRho® SDF) **REVISED January 2015**

Written order and signed consent are REQUIRED for all injections. Please complete and SIGN bottom box.

Patient's name:______________________________HC#___________________DOB:________ABO/Rh type:________

- **Known reactions to blood products? No:____ Yes:____ If yes, describe:______________________________**

Important:

1. Maternal antibody screen must be obtained within 14 days before administration of WinRho.
   If blood work and injection are being done on the *same day* please do both at the *same facility.*
   Dartmouth outpatient Lab hours: 7:00 am to 3:00 pm Monday – Friday (except holidays).
   IWK outpatient lab hours: 7:30 am to 5:00 pm [arrive by 3:30 pm if also coming for glucose ("trutol") testing].
2. Kleihauer test may be indicated for bleeding after 12 weeks gestation

- **Indication:**

  □ **Routine 28 weeks:** WinRho® SDF 300 micrograms. **Patient must bring signed WinRho CONSENT & ORDER.**
  - **IWK Health Centre:** ask patient to **call 902-470-6640** to book their appointment.
  - **Dartmouth General:** Monday, Wednesday and Friday ONLY from 1:30 to 3:30 pm. Walk in (no appointment).

  □ **Bleeding in pregnancy:**
  Non-emergent bleeding: Daily including weekends, 9:00 am to 4:00 pm (excluding stat holidays).
  - **Patient or physician to call IWK Health Centre at 902-470-6640** to book appointment (within 72 hours of bleeding).
  - **Patient must bring signed CONSENT & ORDER for WinRho to *IWK Women's site, 7th floor, Obstetrical Day Unit* (or FAX both forms to 902-470-8269).**

  □ **Urgent/emergent situations:** local emergency department.

  □ **Other indication** (explain):____

- ***Dosage (please check):***

  ***BEFORE** 12 weeks gestation:* □ WinRho® SDF 120 micrograms (if not available give 300 micrograms)
  ***AFTER** 12 weeks gestation:* □ WinRho® SDF 300 micrograms

Signature/Status of Treating Health Professional: ____________________________________
[Physician, Nurse Practitioner or Midwife]

Print Name: ____ ***Date:***____________***(DD/MM/YY)***