Rh PROGRAM of NOVA SCOTIA
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Halifax, Nova Scotia, Canada, B3K 6R8
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Rho(D) IMMUNE GLOBULIN (WinRho®SDF) INJECTION REPORTING FORM

Mother's Surname: _____Mother's First Name: _____

Mother's Maiden Name: _____Mother's ABO & Rh type: _____

Mother's Date of Birth: _____/_____/_____ **Health Card #: _____**
DD / MM / YY

Expected Date of Delivery: _____/_____/_____ **Mother's address: _____**
DD / MM / YY

Treating Health Professional*/Clinic:_____

NOTE: **1. An antibody screen should be drawn *within two weeks* ***PRIOR TO*** THE ADMINISTRATION OF Rho(D) IMMUNE GLOBULIN (WinRho®SDF).**
2. WinRho®SDF is a BLOOD PRODUCT. Has consent been obtained by the physician, nurse practitioner or midwife? ☐ Yes
3. Maintain close observation (15 to 30 minutes post administration) for any adverse reactions.
Previous known reactions to blood products?
☐ No ☐ Yes If yes, describe:_____

REASON FOR INJECTION (please check):

- ☐ **Antepartum (28 weeks)**
- ☐ **Amniocentesis**
- ☐ **Ectopic Pregnancy**
- ☐ **Antenatal Bleeding (threatened miscarriage)**
- ☐ **Miscarriage**
- ☐ **Termination of Pregnancy @_____weeks**
- ☐ **Platelet Transfusion**
- ☐ **Postpartum**
  Delivery Date:**_____/_____/_____**
  DD MM YY

Infant's ABO group:**_____ *Rh type:*****_____**

Maternal KLEIHAUER test:
NEG:____ POS:____ % fetal cells:_____

- ☐ **Other indication (Please explain):**
  _____

DATE ADMINISTERED: _____(DD/MM/YY) Hospital/Clinic:_____

GIVEN BY (Signature):_____(Print Name):_____

Route:_____ Lot No: _____ Dosage: _____µg (or _____I.U.)

WHITE COPY (original): Patient's Chart
YELLOW COPY: Rh Program of Nova Scotia
PINK COPY: Hospital Transfusion Service (laboratory)

***Physician/Nurse Practitioner/Midwife**

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NSRHIRF