Rh PROGRAM of NOVA SCOTIA

5850 /5980 University Avenue, PO Box 9700
Halifax, Nova Scotia, Canada, B3K 6R8
Tel 902-470-6458 (not for booking appointments; see below)
Website: http://rcp.nshealth.ca/rh

ORDER for Rho(D) immune globulin (WinRho® SDF) *****REVISED November 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.
   *Exception: within 72 hours if booking your injection at Dartmouth General Outpatient Department.
   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 and Booking details:**

□ **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:** ask patient to **call 902-465-8335** to book their appointment.

□ **Non-Emergent Bleeding in pregnancy:**
- **Patient or physician to call** to book appointment (within 72 hours of bleeding).
- **Patient must have been assessed by physician and must bring signed CONSENT & ORDER for WinRho**

SITES: a) IWK Health Centre ph 902-470-6640 Daily including weekends (excluding stat holidays)
IWK Women's site, 7th floor, Obstetrical Day Unit **(or FAX both forms to 902-470-8269)**
b) Dartmouth General Outpatient Department ph 902-465-8335 Monday to Friday ONLY

□ **Other indication** (explain):____

Note: Urgent/emergent situations: direct patient to local emergency department (do not use this form).

- ***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)