nova scotia health | IWK Health

ORDER SET

Component Transfusion - Rho(D) Immune Globulin (WinRho® SDF)

Patient: ______________________ ❑ Alert record review ❑ No known allergies

Allergies - Adverse Reactions - Cautions: ______________________

Age _______ Weight _______ kg Date of weight (YYYY/MON/DD): ____________ BSA _______ m²

Items preceded by a **bullet** (•) are active orders. Items preceded by a **checkbox** (❑) are only to be carried out if checked.

- Consent obtained: ❑ Yes ❑ No

Rho(D) Immune Globulin Indication

Pregnancy Related

❑ Routine 28 weeks
❑ Antenatal bleeding
❑ Pregnancy loss
❑ Postpartum
❑ Other pregnancy related risk of fetomaternal hemorrhage (specify): ______________________

Other Indications (Rh negative)

❑ Platelet transfusion - if platelet donors are Rh(D) positive give 120 micrograms (covers up to 6 full buffy coat or apheresed platelet units transfused)
❑ Rh(D) positive red blood cells (RBC) to Rh(D) negative recipient - give 24 micrograms/mL RBC transfused

Dosage

Pregnancy event BEFORE 12 weeks gestation
❑ Rho(D) immune globulin 120 micrograms IM/IV x 1 dose (if not available give 300 micrograms)

Pregnancy event AFTER 12 weeks gestation
❑ Rho(D) immune globulin 300 micrograms IM/IV x 1 dose protects Kleihauer result 0 % to 0.5 % (0 to 0.005)

Postpartum (infant Rh positive, Rh indeterminate, or Rh unknown)
❑ Rho(D) immune globulin 120 micrograms IM/IV x 1 dose protects Kleihauer result 0 % to 0.2 % (0 to 0.002) (if not available give 300 micrograms)

Other / Additional Dosage
❑ Rho(D) immune globulin _______ micrograms IM/IV x _______ dose(s). Repeat x __________

Testing and Forms Required

- Completed order set and signed consent
- Antibody screen before injection
- Kleihauer test may be indicated for events after 12 weeks and postpartum. If Kleihauer result greater than 0.5 % (0.005) - (see guideline for dosing**)
- Rh(D) Immune Globulin (WinRho® SDF) should be administered within 72 hours of event
- Repeat doses may not always be required (see guideline for dosing**)
  Guideline for Perinatal Antibody Screening and Rho(D) immune globulin (WinRho® SDF) Administration **(http://rcp.nshealth.ca/rh)

Date (YYYY/MON/DD) ____ Time (24h/hh:mm) ____ Prescriber Signature ____ Printed Surname / Registration # ____

(IWK Only): Date (YYYY/MON/DD) ____ Time (24h/hh:mm) ____ Verified By (Signature) ____ Printed Surname ____