Rh PROGRAM of NOVA SCOTIA
5850 / 5980 University Avenue, PO Box 9700
Halifax, Nova Scotia, Canada, B3K 6R8
Tel: 902- 470-6458 Fax: 902- 470-7468 http://rcp.nshealth.ca/rh

Rho(D) IMMUNE GLOBULIN (WinRho®SDF) INJECTION REPORTING FORM

Patient's Surname: _____ **First Name:** _____

Date of Birth: _____/_____/_____ **Health Card #:** _____
YYYY/MON / DD

ABO & Rh type: _____ **Expected Date of Delivery:** _____/_____/____
YYYY / MON / DD

Treating Health Professional (*Physician/Midwife/Nurse Practitioner*) /Clinic: _____

1. **An antibody screen should be drawn *within 14 days OR per your facility requirements 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. **Obtain vital signs within one hour pre administration and maintain close observation (minimum 15 Minutes). If a reaction is suspected, refer to Adverse Event Algorithm.**

Previous known reactions to blood products? **□ No □ Yes (describe):**_____

REASON FOR INJECTION (please check):

□ **Antepartum (28 weeks)**

□ **Amniocentesis**

□ **Ectopic Pregnancy**

□ **Antenatal Bleeding (threatened miscarriage)**

□ **Miscarriage**

□ **Termination @**_____**weeks**

□ **Platelet Transfusion**

□ **Postpartum**
Delivery Date: _____ /_____/____
YYYY / MON /DD

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

Maternal KLEIHAUER test:
□ Negative □ Positive Result:_____

□ **Other indication (Please explain):**
_____

DATE ADMINISTERED: _____**(YYYY/MON/DD)** **Hospital/Clinic:**_____

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

Dosage: _____**micrograms (or** _____**I.U.)**

After Transfusion COMPLETE and FAX to:
Rh Program of Nova Scotia (902-470-7468) FAXED BY:_____ **(initials)**
Copied and/or faxed to your local Laboratory if required (Y:____N:____)

REV 2021/JUN