Name:
DOB:

# Physician Order: Administration of $Rh_O$(D)-Immune Globulin (RhoGam®)

| Allergies / Reactions: |
|---|
| |
| |

Date to be injected: ____________________
(Schedule with and fax to Surgical Services)

☐ RhoGAM® 300 microgram dose (1 vial) ☐ Additional vials (specify quantity) _____

**Transfusion questions (order is not complete unless all three questions are answered):**

1. Has Patient been pregnant or transfused in the last 3 months?
   ☐ Yes ☐ No ☐ Not Known
2. Does Patient have any known antibodies?
   ☐ Yes (Anti -________) ☐ No ☐ Not Known
3. Questioner's Initials and Date: _____________ ____/____/________

**Indication:**

Antepartum:

☐ One full dose vial administered to ALL Rh-negative women with pregnancy at twenty-eight (28) weeks gestation.

☐ One full dose vial for: Specify gestation: _____ weeks. (1)
- ☐ Abortion
- ☐ Miscarriage
- ☐ Vaginal hemorrhage
- ☐ Ectopic pregnancy
- ☐ Abdominal trauma

☐ One full dose vial after amniocentesis (except if infant is Rh negative or mother has anti-D not due to antepartum $Rh_o$(D)-Immune Globulin administration) (1)

Postpartum:

☐ All Rh-negative mothers with Rh-positive infants (1)

☐ Fetal maternal hemorrhage greater than or equal to 15 ml of red blood cells. (1)

Other:

☐ Rh-positive platelets administered to an Rh-negative patient (2)

I have discussed with the patient the benefits and risks of administering this product.

________________________________ ____________ ___________
**Physician Signature** **Date** **Time**

**(1) Includes ABO/Rh and Fetal Screen. Based on blood bank history, may also include antibody screen. Positive Fetal Screen will reflex to Kliehauer-Betke assay to determine additional dosage.**

**(2) Includes ABO/Rh. May also include antibody screen if no recent blood bank history is on file.**

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