|  |  |
| --- | --- |
| **Patient:**  **RhoGAM® [Rho(D) Immune Globulin (Human)]** | **DOB:** |
| \*\*check appropriate box\*\*  **\*\*All orders with ☒ will be placed unless otherwise noted\*\*** | |
| **Required lab results and/or tests prior to scheduling:**  Antibody Screen   |  |  |  |  | | --- | --- | --- | --- | | **Height:** | **Weight:** | **Allergies:** | **ICD 10/Primary Diagnosis:** | | |
| **Gestational age:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_W \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_D as of: \_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/20\_\_\_\_\_\_\_\_\_** | |
| **Infusion Therapy** | |
| RhoGAM (300 µg) (1500 IU) injection x 1 | |
| **PRN EMERGENCY MEDS:**  Per Facility protocol  Provider requested Emergency Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Labs** | |
| **Labs drawn prior to scheduling infusion (results provided)**  Antibody Screen | |
| **Nursing Communication/Orders** | |
| * **If OB patient needs Emergency Medication(s) while in Infusion, call the On-Call OB.** * **Prior to Rhogam administration confirm:**   + Rh factor Negative   + Antibody screen identification #1 Negative * Vital Signs PRN | |