PENINSULA HEALTH

ANTI-D IMMUNOGLOBULIN PATIENT CONSENT, ORDER & ADMINISTRATION

UR NUMBER.....

SURNAME.....

GIVEN NAMES.....

DATE OF BIRTH .....
Please fill in if no Patient Label available

26/05/14 - Print Code:13998

PHF553120:

ANTI D IMMUNOGLOBULIN PATIENT CONSENT

I,.....
(patient name in full)

of.....
(address in full)

Understand that:

(a) My medical practitioner / midwife / nurse has recommended that I have an injection of Anti-D Immunoglobulin.

(b) The Anti-D Immunoglobulin (Rh (D) Immunoglobulin) has been prepared from voluntary blood donors.

(c) For medical products made from human blood (e.g. Anti-D Immunoglobulin) it is not possible to completely eliminate the risk that they may carry infections (e.g. HIV / HBV / HCV / HTLV-1 / Syphilis, unknown other) despite stringent screening and strict controls on blood donors.

(d) As with all medications, the benefits of Anti-D Immunoglobulin treatment must be balanced against the possible risks of using it.

(e) If Anti-D Immunoglobulin were not used at all, babies of Rh (D) Negative mothers may be affected by the serious complications of Haemolytic Disease of the Newborn (e.g. severe anaemia, brain damage and even death of the baby in some cases).

I have read the above: and **ACCEPT** or **DECLINE** the treatment (please circle).

.....	.....	..... / ..... / .....
Signature of Patient / Guardian	Print Name	Date
.....	.....	..... / ..... / .....
Signature of Doctor / Midwife	Print Name	Date

Written information has been offered such as:

- You and your baby, Important information for Rh(D) Negative Women
- Important information for Rh(D) negative women

Record Anti-D Immunoglobulin Administration over page.

PENINSULA HEALTH
Anti D Immunoglobulin Patient Consent, Order & Administration cont.

UR NUMBER .....
SURNAME .....
GIVEN NAMES .....
DATE OF BIRTH .....
Please fill in if no Patient Label available

This form can be used for more than one order

1. Routine Administration Antenatal

ANTENATAL PROPHYLAXIS	DATE	MATERNAL ANTIBODIES	PRODUCT	DOSE	BATCH NO.	EXPIRY	Person giving Anti-D (Sign and date)
28 Weeks Gestation ☐			Rh (D) Ig	625 IU			
Authorising Doctor's Signature ..... Print Name ..... Date ...../ ...../							
34 Weeks Gestation ☐			Rh (D) Ig	625 IU			
Authorising Doctor's Signature ..... Print Name ..... Date ...../ ...../							

2. Routine Administration Post natal

POSTPARTUM	DATE	MATERNAL ANTIBODIES	KLEIHAUER	PRODUCT	DOSE	BATCH NO.	EXPIRY	Person giving Anti-D (Sign and date)
Baby Rh **POS** ☐			NEG ☐ **POS** ☐ Date:	Rh (D) Ig	625 IU			
Authorising Doctor's Signature ..... Print Name ..... Date...../ ...../								

3. Sensitising events

SENSITISING EVENTS	DATE	MATERNAL ANTIBODIES	KLEIHAUER	PRODUCT	DOSE	BATCH NO.	EXPIRY	Person giving Anti-D (Sign and date)
Gest:			Not Done ☐ NEG ☐ **POS** ☐ Date:	Rh (D) Ig				
Authorising Doctor's Signature ..... Print Name ..... Date ...../ ...../								
Gest:			Not Done ☐ NEG ☐ **POS** ☐ Date:	Rh (D) Ig				
Authorising Doctor's Signature ..... Print Name ..... Date ...../ ...../								