MR056.1

Ballarat Health Services
Putting your health first

Rh D Immunoglobulin Patient Consent and Administration

U.R. Number _____

Surname: _____

Given Names: _____

D.O.B.: / / Sex: _____

USE ID LABEL IF AVAILABLE

I, ...
(patient name in full)

Understand that:

a) My medical practitioner / midwife / nurse has recommended me to have an injection(s) of Anti-D immunoglobulin.

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

c) As with all medications, the benefits of Rh D Immunoglobulin treatment must be balanced against the possible risks of using it.

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

e) For medical products made from human blood [e.g. Rh 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.

I have read the above and **ACCEPT** or **DECLINE** the treatment (Please circle)

If decline, reason _____

I have been given written information ☐ Yes ☐ No

✘ _____ _____/_____/_____
Signature of Patient / Guardian Date

✘ _____ _____/_____/_____

Rh D IMMUNOGLOBULIN ADMINISTRATION RECORD Date: __/__/_____

Gestation	Maternal Antibodies	DOSE	BATCH No	EXPIRY	Person giving Anti-D (Sign and Date)
☐ **28 Weeks Gestation**		**625 IU**			
☐ **34-36 Weeks Gestation**		**625 IU**			
☐ **Postpartum Baby Rh POS**		**625 IU**			
☐ **Sensitising Event** **Gestation**_____ Single ☐ Multiple ☐		☐ **625 IU** ☐ **250 IU**			

BHS PS
Aug 13

CONSENT AND ADMINISTRATION Rh D Ig MR/056.1