

**HUMAN ANTI-D ANTIBODY  
PRODUCT REQUEST FORM**

UR NUMBER .....

SURNAME .....

GIVEN NAMES .....

DATE OF BIRTH .....

Please fill in if no Patient Label available

Rev. 19/04/06- 12455

Ordering Physician .....

Patient's Blood Group .....

STRENGTH	PRODUCT	INDICATION	✓ request	DATE
250 IU	Rh D Immunoglobulin (Human Anti-D antibody)	1st trimester sensitising events		
625 IU	Rh D Immunoglobulin (Human Anti-D antibody)	2nd & 3rd trimester sensitising events		
		Routine antenatal prophylaxis at 28 weeks		
		Routine antenatal prophylaxis at 34 weeks		
		Post partum		

Date	Medication	Dose	Route	Dr's Signature	Time Given	Given by
	Human Anti-D Antibody		IM			
	Human Anti-D Antibody		IM			
	Human Anti-D Antibody		IM			
	Human Anti-D Antibody		IM			
	Human Anti-D Antibody		IM			

**Details of Anti-D Immunoglobulin Administration**

**Date Given:** ..... / ..... / .....      **Expiry Date:** ..... / ..... / .....

**Dose volume:** ..... ml      **Batch Number:** .....

**Date Given:** ..... / ..... / .....      **Expiry Date:** ..... / ..... / .....

**Dose volume:** ..... ml      **Batch Number:** .....

**Date Given:** ..... / ..... / .....      **Expiry Date:** ..... / ..... / .....

**Dose volume:** ..... ml      **Batch Number:** .....