McLAREN CENTRAL MICHIGAN
1221 SOUTH DRIVE, MT. PLEASANT, MI 48858

PATIENT LABEL

AUTHORIZATION OF MOTHER

AUTHORIZATION AND PROCEDURE
SEND BOTH COPIES TO LABORATORY

3 Hole 1/4 4 1/4 c-to-c

I understand that I am a possible candidate for RHo (D) Immune globulin and that the indications for this have been explained to me.

☐ **If indicated, I accept this medication.**

☐ **After explanation, I refuse this medication.**

PATIENT _____ PHYSICIAN _____

WITNESS _____ **Date** MO. DAY YEAR _____

PROCEDURE (Complete only if authorized above)

DETERMINE MATERNAL ANTIBODY TITER AT TERM

IF

POSITIVE TITER → **NO FURTHER ACTION**

NEGATIVE TITER → **IF**

IF

- **PATERNITY FACTOR NEGATIVE**
- **PATERNITY FACTOR POSITIVE** → **FURTHER ACTION**

☐ **ABORTION OR MACERATED STILLBORN** → **Notify Blood Bank no baby blood to follow**

BABY:
At delivery draw 5 cc. of cord blood (be certain that it is not contaminated with mother's blood running down outside of cord). Place in (clotted) tube and send to Blood Bank, indicating clearly that this is Baby's blood.

Received by Blood Blank:
Signature _____
Date: Time

MOTHER:
Draw 10 cc. of mother's blood (clotted) and sent to Blood Bank with BLOOD BANK REQUEST signed by RN.

Received by Blood Blank:
Signature _____
Date: Time

☐ **MOTHER IS NOT CANDIDATE FOR IMMUNE GLOBULIN**
No further action, EXCEPT

☐ **MOTHER IS CANDIDATE FOR IMMUNE GLOBULIN**
IMMUNE GLOBULIN INDICATED. FURTHER ACTION

NOTIFY NURSE

Called to _____ RN by _____ Date: _____ Time _____
TECH.

IMMUNIZATION GIVEN:

AMT.: TIME: RN SIGNATURE _____

3400B

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PATERNITY FACTOR POSITIVE → **FURTHER ACTION**

FURTHER ACTION

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