

AUTHORIZATION OF MOTHER

AUTHORIZATION AND PROCEDURE
SEND BOTH COPIES TO LABORATORY

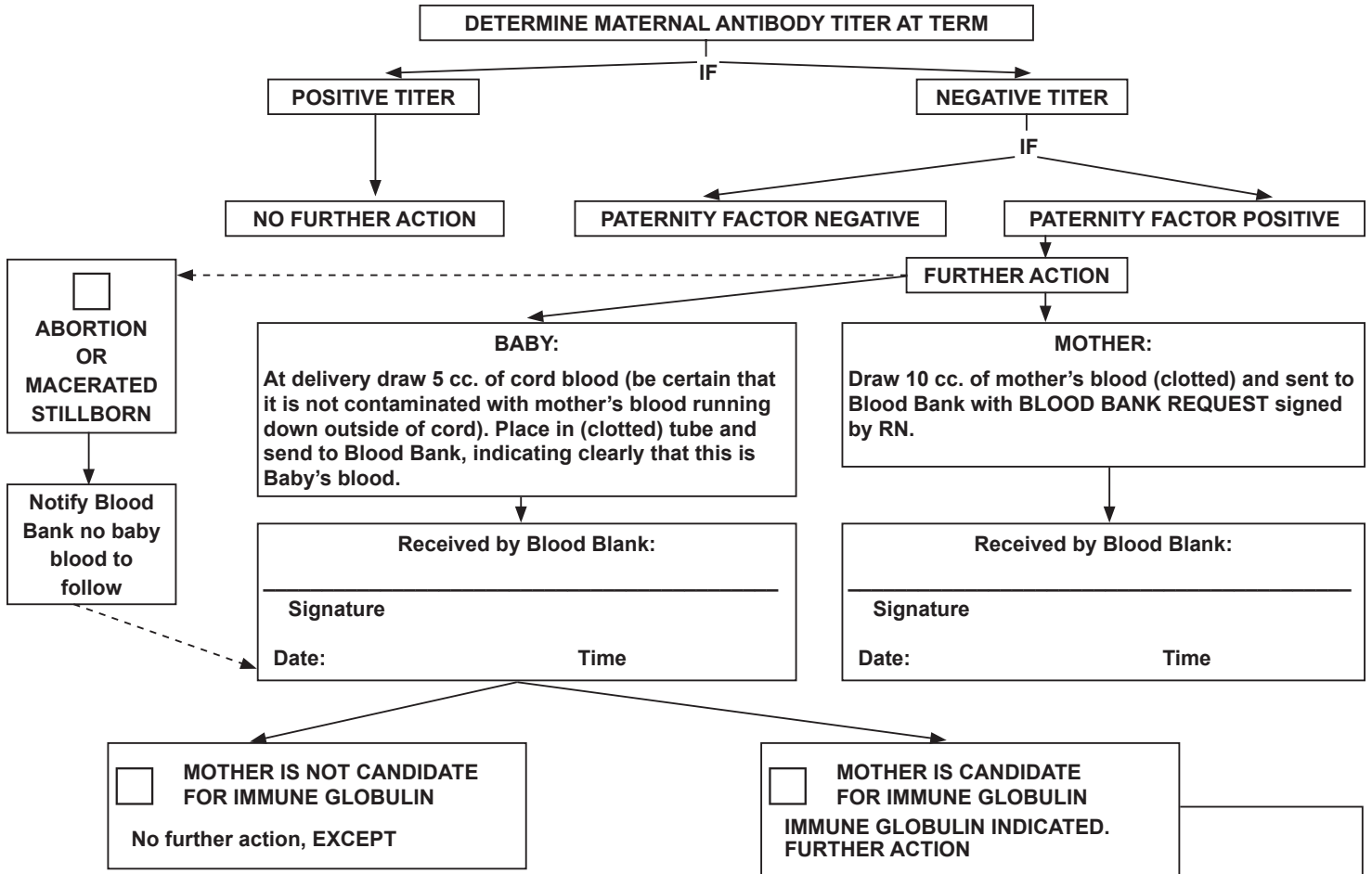
PATIENT LABEL

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. _____ PATIENT _____ PHYSICIAN

After explanation, I refuse this medication. _____ WITNESS _____ Date _____ MO. _____ DAY _____ YEAR _____

PROCEDURE (Complete only if authorized above)



NOTIFY NURSE

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

IMMUNIZATION GIVEN:

AMT.: _____ TIME: _____ SIGNATURE _____ RN _____



3400B

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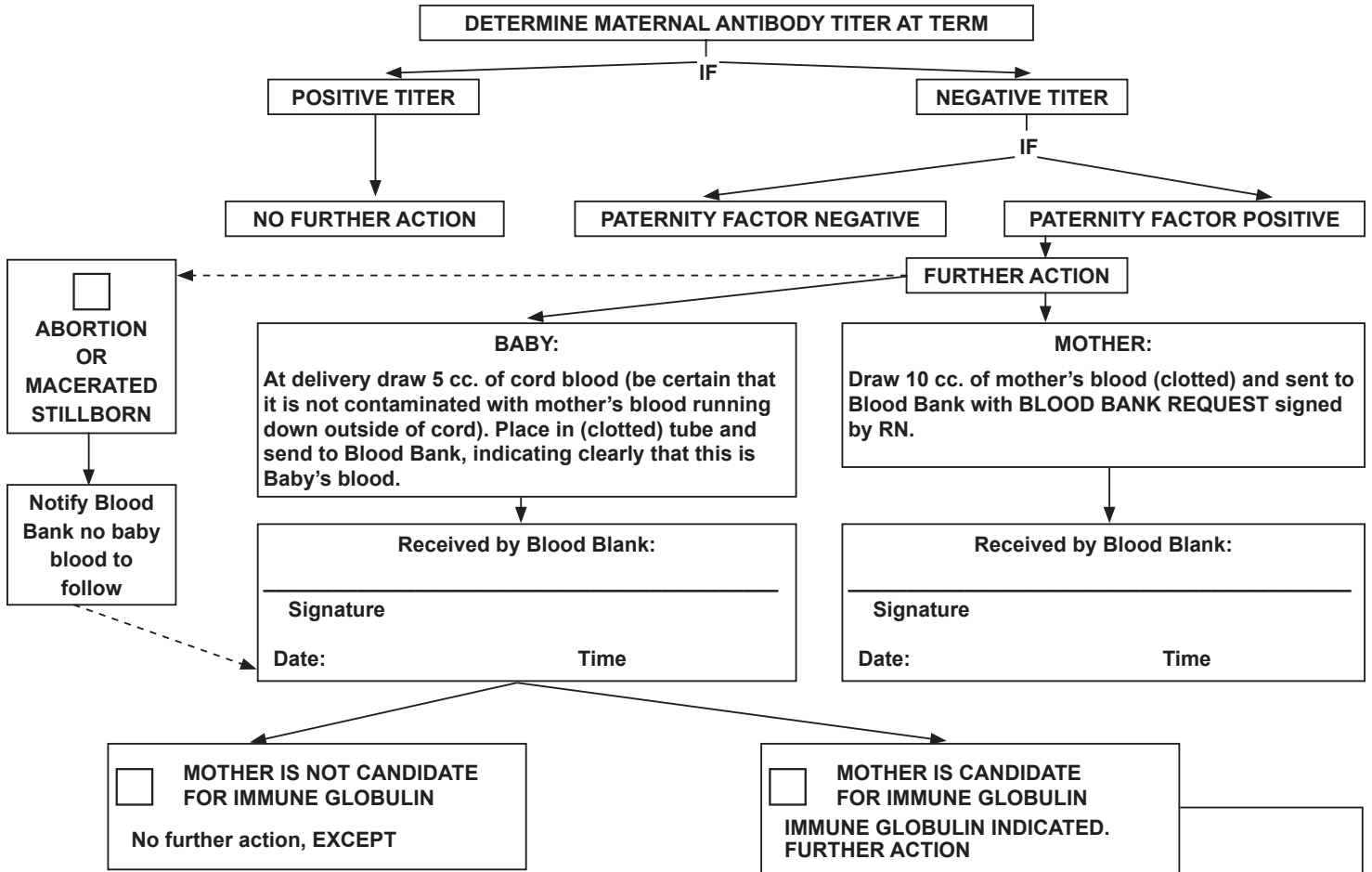
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