



ST. LUKE'S
915 East First Street
Duluth, MN 55805

TEST NAME	Rh Immune Globulin: Clinic Request
MNEMONIC	N/A
TESTING DEPT/PHONE #	5301
SPECIMEN REQUIRED	N/A
VOLUME	N/A
CONTAINER	N/A
FASTING	N/A
PATIENT PREPARATION	None

SPECIAL SAMPLE REQUIREMENTS

Rh Immune Globulin (Rhlg) may be administered to prevent alloimmunization of an Rh(D) Negative woman during pregnancy. Active Anti-D in the mother has been found to cause Rh hemolytic disease of the fetus or newborn. A 300 µg dose of Rh Immune Globulin is indicated for an Rh(D) Negative female in the following situations during pregnancy:

- Antepartum prophylaxis at 26 to 30 weeks
- Antepartum fetomaternal hemorrhage (suspected or proven) as a result of placenta previa, amniocentesis, chorionic villus sampling, percutaneous umbilical blood sampling, other obstetrical manipulative procedure or abdominal trauma
- Actual or threatened pregnancy loss at any stage of gestation
- Ectopic pregnancy

Please complete the following information and fax to St. Luke's Transfusion Services at 218-249-5545.

TAT: Please allow five business days for the delivery of the product.

For Rh Immune Globulin requests not specific to a patient, please fill out the section below.

Requesting Location			
<input type="checkbox"/> BAY AREA	<input type="checkbox"/> DIMA	<input type="checkbox"/> MC (Miller Creek)	<input type="checkbox"/> RUDIEASSOC
<input type="checkbox"/> CHEQUAM	<input type="checkbox"/> HIBBFMC	<input type="checkbox"/> MTROYAL	<input type="checkbox"/> SLINTMED
<input type="checkbox"/> DEN	<input type="checkbox"/> MARINMC	<input type="checkbox"/> NLANDFAM	<input type="checkbox"/> OTHER:
Quantity Requested			
<input type="checkbox"/> One	<input type="checkbox"/> Two	<input type="checkbox"/> Three	<input type="checkbox"/> Four
<input type="checkbox"/> Five	<input type="checkbox"/> Other _____		

For patient specific Rh Immune Globin, please fill out the section below

Patient Name: Last	First	Middle
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Physician Signature

Diagnosis Code

Bill To	<input type="checkbox"/> Client (Please check one of the following clients)	<input type="checkbox"/> Medicare (Please complete the Policy Holder, ID and Group Numbers below)
	<input type="checkbox"/> Medicaid (Please complete the Policy Holder, ID and Group Numbers below)	<input type="checkbox"/> Insurance (Please complete the Policy Holder, ID and Group Numbers below)

<input type="checkbox"/> BAY AREA	<input type="checkbox"/> DIMA	<input type="checkbox"/> MC (Miller Creek)	<input type="checkbox"/> RUDIEASSOC
<input type="checkbox"/> CHEQUAM	<input type="checkbox"/> HIBBFMC	<input type="checkbox"/> MTROYAL	<input type="checkbox"/> SLINTMED
<input type="checkbox"/> DEN	<input type="checkbox"/> MARINMC	<input type="checkbox"/> NLANDFAM	<input type="checkbox"/> OTHER:

POLICY HOLDER	
ID NUMBER	GROUP NUMBER
Responsible Party	DOB
Address	
City	State
	Zip

Blood Bank Instructions:	1. Order and receive RHIG in the LIS
	2. Assign Rhlg to patient
	3. Complete the Rhlg Control Form
	4. Transfer the Rhlg in the LIS
	5. Cancel the product order in the LIS
	6. Package Rhlg in a styrofoam container with a copy of the completed request form
	7. Place the container in the courier pick-up area. Notify courier of need to pick-up.

<p>Rh Immune Globulin Clinic Request Form LAB 400 Version 4 Rev 06/2024</p>	<p>Patient Information Sticker</p>
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