I. POLICY:

Rh Immune Globulin (RhIG) will be given per provider order to a non-sensitized Rh Negative mother within 72 hours following delivery or antepartal procedure as follows.

1. Indications - Antepartum:
   A. Following a miscarriage
   B. Following CVS, PUBS
   C. Following an ectopic pregnancy
   D. Documented or suspected antepartal bleed
   E. Post amniocentesis - genetic or term
   F. 28 weeks gestation to a non-sensitized patient
   G. Cordocentesis
   H. Blunt abdominal trauma
   I. Fetal death

2. Indications - Postpartum:
   A. Infant's blood type is Rh Positive
   B. Infant's blood type is Rh Negative with a Positive Direct Coombs Test
   C. Infant's blood type is Rh Negative with a week D (Dₐ) Positive Test
   D. Infant’s blood type is unknown

II. PURPOSE:

To prevent Rh sensitization of Rh Negative women after delivery or other sensitizing event listed above.

III. PROCEDURE:

<table>
<thead>
<tr>
<th>Responsible Person:</th>
<th>Action:</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN</td>
<td>1. Obtain blood type and antibody screen results of mother. Obtain newborn blood type from cord blood or by heelstick. Consult indications in policy statement 1-I above for RhIG eligibility.</td>
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<tr>
<td></td>
<td>2. If indicated, obtain order for Rhogam workup.</td>
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</tbody>
</table>
Lab 3. Draw sample for Rhogam workup (7 ml. lavender tube). Collect sample at least one hour after delivery.

RN 4. Obtain results of Rhogam workup (ABO Rh, Antibody Screen, and Fetal Screen).

5. If Fetal screen test is positive, obtain order for Fetaldex (Kleinhauer-Betke) Test. Fetaldex test is performed in Haematology.

6. If the Fetaldex test is negative, one vial of Rho (D) Immune Globulin should be administered.

7. If the Fetaldex test is positive, additional vials of Rhogam are required. One vial (300 ug) is needed for each 15 ml bleed of fetal red cells. Because the quantification of fetal bleed is inherently imprecise and because the consequences of undertreatment can be serious, one extra vial is always given when Fetaldex is positive.

Example:
15 ml bleed = 1 vial + 1 extra
30 ml bleed = 2 vials + 1 extra etc
Not more than five doses of RHIG should be injected intramuscularly at one time. For larger quantities, injections can be spaced over 72 hour period.

8. See Lab Fetaldex report for Rh Immune Globulin dosage requirements. Notify physician to obtain an order to administer Rh Immune Globulin in the prescribed dose.

9. Obtain written consent (Appendix A: Form #L-46 – Consent to Administer Rh Immune Globulin) from patient before the administration of Rh Immune Globulin.

10. Obtain Rh Immune Globulin from the Pharmacy and administer intramuscularly within 72 hours of giving birth or after any of the other sensitizing events listed on page one.

11. Evaluate patient for any subsequent sensitizing events that may require additional treatment.

PRECAUTIONS:

Administration of Rh Immune Globulin (RhIG) during pregnancy may produce a positive antibody screen in the mother. Approximately 10% (20-30 ug) of RhIG will be present at delivery and can be detected and identified as anti-D. Anti-D due to RhIG may remain in the maternal circulation for as long as 6 months after administration. This Anti-D should not be interpreted as active immunization and the postpartum RhIG dose should be given if the newborn is Rh positive or weak (D) Du positive.

DOCUMENTATION:

Rh Immune Globulin is documented as per SPUH Protocol. The Control Form (See attached Appendix B) must be filled out completely, including lot number and expiration date printed on injection. The completed form is then to be stapled to:
A. Progress notes and documented in the electronic medical record.
B. In the electronic medical record in the Women’s Clinic, LDR and P.E.T. Room.

IV. REFERENCES:


Approved by:

<table>
<thead>
<tr>
<th>Signature</th>
<th>CNO/Vice President – Patient Care Services</th>
<th>6/6/11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature</td>
<td>Title</td>
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<tr>
<td>Signature</td>
<td>Director – Women &amp; Children’s Division</td>
<td>6/6/11</td>
</tr>
</tbody>
</table>

Origination Date: 8/92
Supersedes Date(s): 2/00, 9/10/01, 4/19/04, 6/6/06, 9/17/07, 6/6/11
Reviewed Date: 5/98, 2/99, 2/06,
Revised Date: 1/20/00, 6/01, 4/04, 8/07, 4/11

647-7.0 (and 645-7.0 & 681-7.0)
CONSENT FOR Rh IMMUNE GLOBULIN ADMINISTRATION

DATE: ___________________ TIME: ___________________

I consent to receive Rh Immune Globulin, also known as Rhogam.

Rh Immune Globulin is a medication given to Rh Negative patients to protect against foreign Rh Positive red cells that may enter the blood stream of a pregnant woman during pregnancy or after delivery of an Rh Positive infant.

_____ 1. I understand that no warranty or guarantee has been made to me as to results of this treatment.

_____ 2. The purpose of the treatment, its favorable results as well as possible adverse effects upon future children (should treatment be refused) have been explained to me.

_____ 3. I have been given the opportunity to ask questions.

_____ I DO NOT WISH TO RECEIVE Rh IMMUNE GLOBULIN.

Signature of Patient, Health Care Representative or Legal Guardian

___________________________

Relationship

DATE: _____________     TIME: _____________

Witness

DATE: _____________     TIME: _____________

Interpreter or Reader’s Signature --or—Telephone Interpreter ID #
CONSENTIMIENTO PARA LA
ADMINISTRACIÓN DE INMUNOGLOBULINA Rh

FECHA:_________________           HORA: ___________________

Acepto recibir inmunoglobulina Rh, también conocida como RhoGAM.
La inmunoglobulina Rh es un medicamento que se administra a los pacientes con sangre Rh negativo para protegerlos de los glóbulos rojos extraños Rh positivos que pueden invadir el torrente sanguíneo de una mujer durante su embarazo o después de dar a luz a un bebé con sangre Rh positivo.

1. Entiendo que no se me ha garantizado el resultado de este tratamiento.
2. Me han explicado el objetivo de este tratamiento, los resultados favorables y los efectos adversos para mis futuros hijos (en caso de rehusar el tratamiento).
3. He tenido la oportunidad de hacer preguntas.

______ NO DESEO RECIBIR INMUNOGLOBULINA Rh.

_________________________________________________  FECHA:____________  HORA: _____________

Firma del paciente, representante de atención de salud o tutor legal

______________________________________________
Parentesco

_________________________________________________  FECHA:____________  HORA: _____________

Testigo

Firma del interprete o lector --o-- número de identificación del interprete por teléfono.