RhoGAM®/WinRho® referral form

Primary Care Network
CALGARY WEST CENTRAL

RhoGAM®/WinRho® injection through the Calgary West Central Primary Care Centre

RhoGAM®/WinRho® injection to be given on this date: _____

(Date determined by referring physician.)

Patient name: _____

PHN: _____ DOB (dd/mm/yyyy): _____

Address: _____

City: _____ Province: _____ Postal code: _____

Phone (H): _____, (C): _____

☐ **Patient advised** of the **risks, benefits,** and **side effects** of RhoGAM®/WinRho®.

LMP: _____

EDD: _____

Threatened miscarriage: _____

ABO/Rh and Antibody Screen: **Attach copy of screening completed within the previous nine months.**

Physician name: _____

Clinic: _____, PRAC ID: _____

Clinic address: _____

City: _____ Province: _____ Postal code: _____

Clinic phone: _____, Clinic fax: _____

Physician name *(please print)*: _____

Physician signature: _____ Date: _____

Please **fax** to the **CWC Primary Care Centre** at **403.258.2748**.