Primary Care Network
CALGARY WEST CENTRAL

AGREEMENT

WinRho®

WinRho® Injection through the Calgary West Central Primary Care Centre.

WinRho® injection to be given on this date: _____

(Date determined by referring physician.)

Patient name: _____

PHN: _____ DOB (DD/MM/YYYY):_____

Address: _____

Telephone (H): _____, (C):_____

☐ **Patient has been advised of risks, benefits and side effects of WinRho®.**

LMP: _____

EDD: _____

Threatened miscarriage: _____

ABO/Rh and Antibody Screen: ***Attach most recent copy.***

Physician name: _____

Clinic: _____, PRAC ID: _____

Clinic address: _____

Clinic telephone: _____, Clinic fax: _____

Physician name *(please print)*: _____

Physician signature: _____

Date: _____

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