RhoGAM Referral

FAX TO 505-726-4304

RhoGAM Referral

PT:_____ **DOB:** _____ **(FEMALE)**

ADDRESS:_____

CITY/CA/ZIP_____

PHONE: _____ **ALT:**_____

ALLERGIES:_____ **/ NKDA**

INSURANCE: _____ **ID#:**_____

GRP:_____

RX: RhoGAM 300 ug syringe x 1 dose
SIG: ***OFFICE USE*** inject intra-muscularly at 26 to 28 week of gestation.

PLEASE SUBMIT ORDER TO PHARMACY 2 BUSINESS DAYS PRIOR TO INJECTION

Delivery option:

Pt pick up @ pharmacy:_____ Deliver to MD office:_____

DR:_____ DATE:_____

PRINT:_____ NPI:_____

PHONE: _____ FAX:_____