XC301400

Hospital_____

Specialised Medication Rituximab Pre-Infusion Checklist

Surname	UMRN / MRN	
Given Name	DOB	Gender
Address		Post Code
	Telephone	

Ward:	Bed:	Admission Date:

Document any changes in medical condition in the patient's medical notes.

Refer to each consultant's specific instructions where appropriate.

CHECKLIST	COMMENTS
☐ The consent form has been completed (including review of relevant blood test results) by the referring consultant **prior** to the first booking (see referral)	
☐ The patient has taken the appropriate premedication as prescribed by the referring consultant.	
☐ The patient is **not** suffering from any infections (acute, chronic or localised)	
☐ Consideration has been given to withholding antihypertensive medication for at least 12 hours prior to the appointment.	
☐ The patient does **not** have an allergy to mice (murine proteins)	
☐ The patient has been advised to monitor for skin reactions post-infusion	
☐ Patient has been offered a Consumer Information leaflet and the opportunity to ask any questions relating to the medication prior to infusion	
☐ The patient has been reviewed by the referring consultant within the last six months (see referral)	

Patient's Signature	
Nurse's Signature:	
Nurse's Name *(please print)*:	
Designation:	
Date:	

Please refer to Specialised Medication - Rituximab Guideline

regarding administering of this infusion.

Please file this checklist with the relevant Medication Chart.

Information in this pre-infusion checklist is specific to Mabthera®

WACHS MR173D SPECIALISED MEDICATION - RITUXIMAB PRE-INFUSION CHECKLIST