Perinatal Statements

Statement #	Low Risk Statements
L1	For routine care, prenatal testing for ABO, RhD, and antibody screen is recommended after 8 weeks gestation, preferably between 11 and 14 weeks.
L2	A routine ABO, RhD and antibody screen may not be necessary at 28 weeks gestation for either RhD positive or RhD negative pregnancies.
L3	Antibody screening is suggested for all pregnancies (RhD negative and RhD positive) following a sensitizing event or after maternal RBC transfusion.
L4	Maternal ABO, RhD, and antibody screen at the time of delivery is only recommended when: a. there is no prior test during the current pregnancy; and/or b. there is a clinically significant antibody; and/or c. the risk of maternal transfusion is increased; and/ or d. the risk of neonatal transfusion is increased.
L5	RHD genotyping is recommended in any pregnant person with weak or variably reactive RhD typing.
L6	It is recommended that pregnancies with weak or indeterminant RhD and without available RHD genotype results be considered RhD negative until genotyping results are available.
L7	For any pregnancy less than 12 weeks gestational age (12 weeks 0 days) experiencing an abortion (threatened, spontaneous or therapeutic), an ABO, RhD, and antibody screen are not recommended and RhIg is not required.
L8	Informed consent (verbal or written) must be obtained and documented prior to the administration of RhIg.
L9	For RhD negative pregnancies, determination of fetal RhD status by non-invasive prenatal testing (cffDNA testing of maternal plasma) is suggested to avoid unnecessary RhIg administration.
L10	Routine antenatal RhIg at a dose of 300 µg (1500 IU), is recommended for all RhD negative pregnant individuals at approximately 28 weeks gestation.
L11	For sensitizing events in RhD negative pregnancies RhIg dosing varies depending on gestational age of the pregnancy: a. less than 8 weeks 0 days: no RhIg required b. ≥ 8 – 11 weeks: 120 ug (600 IU) for ectopic or molar pregnancies, trauma or invasive prenatal testing (RhIg not required for abortions) c. ≥12-19 weeks: 300 µg (1500 IU) for all sensitizing events d. ≥20 weeks: 300 µg (1500 IU) for all sensitizing events with FMH quantification to determine need for additional doses.
L12	If immune anti-D is detected, RhIg is not recommended.
L13	RhIg is recommended for routine prophylaxis and for sensitizing events in RhD negative pregnancies even when antibodies other than anti-D are present.
L14	In the setting of ongoing or recurrent antepartum bleeding starting at 20 weeks (≥20 weeks 0 days) gestation in an RhD negative pregnancy, both RhIg and FMH testing are recommended.
L15	Following delivery of an RhD positive neonate in an RhD negative pregnancy, RhIg is required within 72 hours of delivery.

L16	Postnatal RhIg dosing (300 µg (1500 IU) or 120 µg (600 IU)) may vary depending on access to FMH test results.
L17	Quantitative FMH testing prior to 20 weeks gestation is not routinely recommended for RhIg dose guidance.
L18	Quantitative FMH testing is required starting at 20 weeks (≥20 weeks 0 days) gestation for pregnancies with a sensitizing event that may lead to FMH.
L19	For sensitizing events starting at 20 weeks gestation (≥20 weeks 0 days), RhIg doses should be based on quantitative FMH assessment with use of a validated calculator.
L20	FMH testing is required postpartum for RhD negative pregnancies with an RhD positive neonate.
L21	Flow cytometry is recommended for confirmation of diagnosis and quantitation of FMH, where feasible.