Rabies Post Exposure Prophylaxis Tracking Form

Immediately Fax Completed Form: 705-725-8132

Attention Rabies Coordinator: Tel 705-721-7520 ext. 8894

<table>
<tr><td colspan="2">Patient Name*:</td><td colspan="2">Date of Birth*:
(YYYY/MM/DD)</td><td colspan="3">Health Care Provider*:</td></tr>
<tr><td colspan="2">Date Due:</td><td>Actual Date Administered</td><td>Product Name Lot Expiry Date</td><td>Injection Site</td><td>Dose</td><td>Health Care Provider Staff Initial</td></tr>
<tr><td>Rabies Immune Globulin (RIG)
(Administer all on Day 0)
☐ IMOGAM
☐ HYPERRAB</td><td>Day 0</td><td>YYYY/MM/DD</td><td>*</td><td>**DO NOT ADMINISTER RIG AT SAME SITE AS VACCINE**

Site of the wound: _______
Other:________</td><td>*</td><td>*</td></tr>
<tr><td colspan="7"></td></tr>
<tr><td rowspan="5">Rabies Vaccine

☐ Imovax
☐ RabAvert</td><td>Day 0</td><td>YYYY/MM/DD</td><td>*</td><td>Deltoid: □ R □ L*
Other:________</td><td>1 vial</td><td>*</td></tr>
<tr><td>Day 3</td><td>YYYY/MM/DD</td><td>*</td><td>Deltoid: □ R □ L*
Other:________</td><td>1 vial</td><td>*</td></tr>
<tr><td>Day 7</td><td>YYYY/MM/DD</td><td>*</td><td>Deltoid: □ R □ L*
Other:________</td><td>1 vial</td><td>*</td></tr>
<tr><td>Day 14</td><td>YYYY/MM/DD</td><td>*</td><td>Deltoid: □ R □ L*
Other:________</td><td>1 vial</td><td>*</td></tr>
<tr><td>Day 28
if Immunocompromised</td><td>YYYY/MM/DD</td><td>*</td><td>Deltoid: □ R □ L*
Other:________</td><td>1 vial</td><td>*</td></tr>
</table>

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*****Vaccine is Never to be released to Patient*****

***** Vaccine is to be kept refrigerated*****

*****Rabies Coordinator is to be contacted if treatment is not completed*****

This information is collected under the authority of the Health Protection and Promotion Act (1990). Any questions regarding the collection of this information may be directed to the Freedom of Information officer at 705-721-7520 or 1-877-721-7520