|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Patient Name:**  **DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Weight:**  **File # NEX-** | | **Physician/Health Care Provider Name:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Date Due: | | **Actual**  **Date Administered** | **Product Name**  **Lot**  **Expiry Date** | **Injection Site** | **Dose** | **Health Care Provider**  **Initial** |
| **Rabies Immune Globulin (RIG)**  Dose Calculation  ***1ml vial HyperRab***  **20 IU/kg x (client wt in kg) ÷ 300 IU/mL = dose in mL**  **Or**  ***2ml vial HyperRab/Imogam/KAMRAB***  20 IU/kg x (client wt. in kg) ÷ 150 IU/mL= | **Day 0**  **\_\_\_\_\_\_\_** | YYYY/MMM/DD\* | Quantity/Boxes\_\_\_\_  Choose an item. | DO **NOT** ADMINISTER RIG AT SAME SITE AS VACCINE As much as possible at site of the wound:  \_\_\_\_\_\_\_  \*  Other:\_\_\_\_\_\_\_\_ |  | \* |
|  | | | | | | |
| **Rabies Vaccine** | **Day 0**  **\_\_\_\_\_\_\_** | YYYY/MMM/DD\* | Choose an item. | \*Deltoid: □ R □ L  Other:\_\_\_\_\_\_\_\_ | 1 vial | \* |
| **Day 3**  **\_\_\_\_\_\_\_** | YYYY/MMM/DD\* | Choose an item. | \*Deltoid: □ R □ L  Other:\_\_\_\_\_\_\_\_ | 1 vial | \* |
| **Day 7**  **\_\_\_\_\_\_\_** | YYYY/MMM/DD\* | Choose an item. | \*Deltoid: □ R □ L  Other:\_\_\_\_\_\_\_\_ | 1 vial | \* |
| **Day 14**  **\_\_\_\_\_\_\_** | YYYY/MMM/DD\* | Choose an item. | \*Deltoid: □ R □ L  Other:\_\_\_\_\_\_\_\_ | 1 vial | \* |
| **ONLY FOR**  **Immunocompromised or**  **taking chloroquine** | **Day 28**  **\_\_\_\_\_\_\_** | YYYY/MMM/DD\* | Choose an item. | \*Deltoid: □ R □ L  Other:\_\_\_\_\_\_\_\_ | 1 vial | \* |

**Please Immediately Fax** Form after **EACH DAY of PEP Administration**: **705-725-8132**

**Refrigerate** vaccine at all times (between **2-8oC**) and **Never release** vaccine to Patient

**Contact** Rabies Coordinator if complete series is not administered

**\* These Sections must be completed/signed by Health Care Provider**