|  |  |
| --- | --- |
| **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 VACCINEAs much as possible at site of the wound: \_\_\_\_\_\_\_\*Other:\_\_\_\_\_\_\_\_  |  | \* |
|  |
| **Rabies Vaccine** | **Day 0****\_\_\_\_\_\_\_**  | YYYY/MMM/DD\* | Choose an item.  | \*Deltoid: □ R □ LOther:\_\_\_\_\_\_\_\_ | 1 vial | \* |
| **Day 3****\_\_\_\_\_\_\_**  | YYYY/MMM/DD\* | Choose an item.  | \*Deltoid: □ R □ LOther:\_\_\_\_\_\_\_\_ | 1 vial | \* |
| **Day 7****\_\_\_\_\_\_\_**  | YYYY/MMM/DD\* | Choose an item.  | \*Deltoid: □ R □ LOther:\_\_\_\_\_\_\_\_ | 1 vial | \* |
| **Day 14****\_\_\_\_\_\_\_**  | YYYY/MMM/DD\* | Choose an item.  | \*Deltoid: □ R □ LOther:\_\_\_\_\_\_\_\_ | 1 vial | \* |
| **ONLY FOR** **Immunocompromised or****taking chloroquine** | **Day 28** **\_\_\_\_\_\_\_**  | YYYY/MMM/DD\* | Choose an item.  | \*Deltoid: □ R □ LOther:\_\_\_\_\_\_\_\_ | 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**