Only to be completed if vaccine recommended by physician
Fax to: 519-376-0980

GREY BRUCE HEALTH UNIT

Human Rabies Vaccine Request Form

To be completed by ORDERING PHYSICIAN

PATIENT Date of Incident _____ Animal Type _____

Name: _____ Birthdate _____ Sex F M

Address: _____ Phone: (___) _____

Health Card #:_____ Patient's Weight, in Kilograms: _____ kg (_____ lbs ÷ 2.2 = # kg)

Is the Patient Immunocompromised? (yes/no) _____

Ordering Physician: _____ Date Ordered by Physician: _____
(First and Last Name)

Delivery location:

_____Hospital Physician's Office _____ Other (specify) _____

To be completed by Health Unit

RIG: Amount _____ RIG: Lot# _____ Expiry: _____

RIG: Lot# _____ Expiry: _____
(Rabies Immune Globulin)

Vaccine: Amount _____ PCECV: Lot# _____ Expiry: _____
(Purified Chick Embryo Cell Vaccine - RabAvert)

Amount _____ HDCV: Lot# _____ Expiry: _____
(Human Diploid Cell Vaccine - Imovax)

Packaged By: _____ Date Packaged: _____ Panorama RID #: _____

Quantities and Lot #s reviewed and verified by PHI _____
Signature

To be completed by RECEIVER of vaccine

Received by: _____ _____ _____
Print Name *Signature* *Date*

To be completed by Health Unit

CLIENT iPHIS ID #: _____ iPHIS #: _____ DATE OF INPUT: _____

Inputted By: _____ Vaccine entered into HealthSpace Yes No