



Rabies Vaccine/Immune Globulin Usage Report Physician's Order

Date: _____ Health Care Facility: _____
yyyy/mm/dd

Telephone No.: _____
 Fax No.: _____

Patient Name: _____ Date of Birth: _____
First Last yyyy/mm/dd

Patient Phone #: _____ HEIGHT: _____ cm WEIGHT: _____ kg

Contraindications: There are NO contraindications to use the rabies vaccine or Rablg after significant exposure

Rabies Immune Globulin _____ mL = (20 units/kg x weight in kg)
 _____ units/mL

- Rabies Vaccine 1 mL IM x 4 doses
 Rabies Vaccine 1 mL IM x 5 doses (for immunocompromised persons)

Description	Name of Vaccine	Number Required	Lot Number(s)	Expiry Date	Date Administered (YYYY/MM/DD)	Initials
Rabies Immune Globulin (RIG)						
Rabies Vaccine (Day 0)						
Rabies Vaccine (Day 3)						
Rabies Vaccine (Day 7)						
Rabies Vaccine (Day 14)						
*Rabies Vaccine (Day 28)						

_____ **Date**

_____ **Physician Signature**

_____ **Physician Print Name**

**Fax completed form to the North Bay Parry Sound District Health Unit at
 (EH) 705-474-9481 and (VPD) 705-474-9399**

(Please keep a copy for your records)