

RENFREW COUNTY AND DISTRICT HEALTH UNIT

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Renfrew County and District
Health Unit

Request for Rabies Post Exposure Vaccine

Reporting Agency:
Reported By:
Date Reported:

INCIDENT & client details

Patient Name:				
Health Card Number:			D.O.B: (yy/mm/dd)	
Gender: M <input type="checkbox"/> F <input type="checkbox"/>	Address:			
City:	Province:	Postal Code:	Home Phone: ()	
Attending Physician:		Telephone: ()		
Family Physician:		Telephone: ()		
Date of Incident: (yy/mm/dd)		Patient Previously Immunized: Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>		
		Immunization Date (yy/mm/dd):		
Prophylaxis Required: Yes <input type="checkbox"/> No <input type="checkbox"/>		Client Weight: _____ Kg		
Details:				
Type of Exposure (circle): BITE HANDLING NEARBY SCRATCH UNKNOWN				
Wound Description:				

ANIMAL/OWNER details (for Health Unit use only)

Owner Name (if applicable):				
Address:			Home Phone:	
City:	Province:	Postal Code:	Work Phone:	
Animal Species (circle): BAT CAT DOG FOX RACCOON SKUNK SQUIRREL CHIPMUNK UNKNOWN OTHER (SPECIFY):				
Animal Type (circle): OUTDOOR PET INDOOR PET STRAY FARM WILD UNKNOWN				
Pet's Name:		Species:	Rabies Shot: Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	
Age:	Description:		Vaccine Type: _____ Date: (yy/mm/dd)	
Quarantine start: (yy-mm-dd)		Quarantine End: (yy-mm-dd)		
Observation Report:		Isolation Termination Report:		
Quarantine Result: HEALTHY <input type="checkbox"/> FATAL <input type="checkbox"/>				
Rabies Status: NEGATIVE <input type="checkbox"/> POSITIVE <input type="checkbox"/> NOT TESTED <input type="checkbox"/>				
Date of Analysis: (YY-MM-DD)		Specimen No.:		
Rabies Immune Globulin #Given _____		Rabies Vaccine #Given _____		
Lot# _____		Lot# _____		
Expiry Date: _____		Expiry Date: _____		
Dosage _____ Unit _____		Dosage _____ Unit _____		
Vaccine Delivered By/ Picked up By:		Total Order Received/Given:		Vaccine Received By/Left With:
		Yes No		