Northwestern Health Unit - RABIES MEDICAL REPORT

NAME OF PATIENT			
ADDRESS			
CITY/TOWN		**POSTAL CODE**	
DATE OF BIRTH		**TELEPHONE**	
PARENT/GUARDIAN (IF APPLICABLE)			

PREVIOUSLY VACCINATED AGAINST RABIES? **YES** ☐ **NO** ☐

MEDICAL TREATMENT RECEIVED

RABIES IMMUNE GLOBULIN

DAY	**DATE GIVEN**	**LOT #**	**COMMENTS**
DAY 0			

RABIES VACCINE

DAY	**DATE GIVEN**	**LOT #**	**COMMENTS**
DAY 0			
DAY 3			
DAY 7			
DAY 14			
DAY 28 (only administered to immunocompromised individuals) If Day 28 is administered enter: Date Given: Lot #:			

Permission to Release Vaccine Given By:	**Fax or mail completed rabies medical reports to:**
Facility Name:	Fax: 807-468-3813
Signature of Person Completing this Report:	Mail: Northwestern Health Unit 210 First St N Kenora, ON P9N 2K4
Date:	
FOR OFFICE USE ONLY	
Enter into iPHIS. : Yes ☐ No ☐	
Immunization Entered into Panorama : Yes ☐ No ☐	
Follow up Complete / Case Closed: Yes ☐ No ☐	
c: Dr. Kit Young Hoon, Medical Officer of Health ☐	

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