

# Phone Report of Possible Rabies Exposure

Manitoba Health  
Communicable Disease Control



No. \_\_\_\_\_

## PATIENT INFORMATION

NAME	AGE	SEX	WT	MESSAGE RECEIVED BY
ADDRESS	TELEPHONE		DATE	
				TIME
PHYSICIAN	TELEPHONE		REPORTED BY	
ADDRESS				TELEPHONE
PREVIOUS RABIES IMMUNIZATION <input type="checkbox"/> YES <input type="checkbox"/> NO				DATE OF LAST TETANUS

## EXPOSURE INFORMATION

DATE OF EXPOSURE	ANIMAL	GEOGRAPHIC LOCATION
WOUND LOCATION	TYPE OF EXPOSURE <input type="checkbox"/> BITE <input type="checkbox"/> SCRATCH <input type="checkbox"/> LICK <input type="checkbox"/> OTHER	
PROVOKED ATTACK? <input type="checkbox"/> YES <input type="checkbox"/> NO	ANIMAL UNDER OBSERVATION? <input type="checkbox"/> YES <input type="checkbox"/> NO	ANIMAL VACCINATED? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> ?
HEAD FORWARDED <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE	INITIAL ASSESSMENT

## OTHER INFORMATION

	RABIES IMMUNE GLOBULIN DOSAGE			
	KG	LB.	VOLUME (ml) (150 I.U./ml)	No. of 2ml vials
	3	7	0.4	1
	4	9	0.5	1
	5	11	0.7	1
	10	22	1.3	1
	15	33	2.0	1
	20	44	2.7	2
	25	55	3.3	2
	30	66	4.0	2
	35	77	4.7	3
	40	88	5.3	3
	45	100	6.0	3
	50	111	6.7	4
	55	121	7.3	4
	60	132	8.0	4
	65	143	8.7	5
	70	155	9.3	5
	75	165	10.0	5
	80	176	10.7	6
	85	187	11.3	6
	90	198	12.0	6
	100	220	13.3	7
	110	242	14.6	8
	120	264	16.0	8

  

<p><b>INITIAL PLAN</b></p> <p><input type="checkbox"/> No further action. <input type="checkbox"/> Observe for 10 days until _____</p> <p><input type="checkbox"/> Look for animal until _____ <input type="checkbox"/> Diarize _____</p> <p>If found: _____</p> <p>If not found: _____</p> <p><input type="checkbox"/> Forward RIG _____ ml HDVC _____ doses _____</p> <p style="text-align: right;">Signature _____</p>
<p><b>FINAL REPORT</b></p> <p><input type="checkbox"/> Animal well at 10 days — NFA <input type="checkbox"/> Animal not found <input type="checkbox"/> FA report positive</p> <p><input type="checkbox"/> FA report negative Close file: Year _____ Mo. _____ Day _____</p> <p><input type="checkbox"/> RIG and VACCINE completed: Year _____ Mo. _____ Day _____</p> <p style="text-align: right;">Signature _____</p>