



Human rabies immunoglobulin and vaccine order form (for public health use only)

THIS FORM IS FOR PUBLIC HEALTH UNIT STAFF ONLY

TREATING CLINICIANS REQUESTING POST-EXPOSURE PROPHYLAXIS (PEP) FOR PATIENTS WITH A POTENTIAL RABIES EXPOSURE MUST CONTACT THEIR PUBLIC HEALTH UNIT OR IF AFTER HOURS CALL 9328 0553.

Process for ordering: Onelink office hours: Mon-Fri 6.30am-4.00pm

1. If the order is being placed after office hours **and** the delivery is also required after hours: Email this form to priority@onelink.com.au and copy vaccineorders@health.wa.gov.au Call (not text) 0459 398 111 to confirm order.
2. For **all other** ordering/delivery timeframes, email this form to customerservice@onelink.com.au and copy vaccineorders@health.wa.gov.au

Order

KAMRAB (HRIG - RW0591): _____ x 2 mL vials To calculate the number of vials required = $(20 \times (\text{patient weight in kg}) \div 150) / 2$

Verorab* (Vaccine - RW0588): _____ x vials *Verorab is safe to use for people with egg allergy.

Attending doctor's name _____ **Phone** _____

Practice/hospital name _____ **Fax** _____

Delivery address _____

Postcode _____

Delivery required (tick box)

Not Urgent Date _____ Time _____ am pm
 Not urgent: Orders placed and approved by Onelink before 2pm AWST will be delivered the following day.

Urgent Date _____ Time _____ am pm
 Urgent: if standard (not-urgent) option will not facilitate delivery in time.

Subsequent order (if required) Note: This is only required if needed for subsequent treatment at different location.

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Delivery address _____

Postcode _____

Delivery required (tick box)

Not Urgent Date _____ Time _____ am pm
 Not urgent: Orders placed and approved by Onelink before 2pm AWST will be delivered the following day.

Urgent Date _____ Time _____ am pm
 Urgent: if standard (not-urgent) option will not facilitate delivery in time.

I hereby authorise the supply of the above quantities of human rabies immunoglobulin and/or human rabies vaccine to the attending doctor(s) named above:

Patient's name _____ **Date of birth** _____

Authorising doctor's name _____ **PHU Name** _____
 (PHU or CDCD)

Date _____ **Time** _____ **am pm** **CDCD**