ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN					
Allergies/Reactions:	Fax all infusions to: 833-3 Please mark the approprio infusion center:		<ul> <li>Allenmore Infusion Center</li> <li>Auburn Infusion Center</li> <li>Gig Harbor Infusion Services</li> <li>Puyallup Infusion Center</li> </ul>	<ul> <li>DHEC Infusion Center</li> <li>North Spokane Infusion Center</li> <li>North Star Lodge Infusion Center</li> </ul>	
ORDERS WITH CHECK BOXES When an order is optional (those with check boxes), physicians are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.					
Rabies Vaccine Orders					
Patient Name:					
Date of Birth:/ Patient				🔄 🛛 May leave message	
ICD -10 Code:           Diagnosis:					
Diagnosis:              Date of first Rabies Vaccine dose (Day 0)://              /					
<b>Required:</b> H&P with documentation to support above diagnosis including ICD-10 code and supporting labs **If required documentation not received with order, scheduling of treatment will be delayed until complete information is available**					
<b>Treatment Regimen:</b> Rabies Vaccine 1 mL intramusclar (deltoid). Will use MHS preferred vaccine, unless contraindicated.					
Preexposure prophylaxis: Give vaccination on Day 7					
<ul> <li>Postexposure prophylaxis:</li> <li>Previously vaccinated patients: Give vaccination on Day 3</li> <li>Previously unvaccinated patients: Give vaccination on Days 3, 7, and 14</li> <li>Give additional vaccination on Day 28 for immunocompromisted patients</li> <li>Vital Signs: Check vital signs prior to and at completion of infusion. Contact primary care provider if systolic BP &gt;180; diastolic BP &gt;100; systolic BP &lt;90; HR &gt;110; temp &gt;38C (100.4F)</li> </ul>					
<ul> <li>If hypersensitivity develops (fever, chills, hypotension, rigors, itching, rash, etc.):         <ul> <li>Consult MultiCare Hypersensitivity guideline for treatment/management</li> <li>Notify primary care provider of reaction, assessment and need for further orders</li> </ul> </li> <li>Code Status: Please note, patients will be considered FULL Code unless marked otherwise. If the patient has a POLST, advance directive or living will, please include a copy with the orders.</li> </ul>					
Was consent obtained: 🗆 Yes 🗅 No (if yes, please send DOCUMENTATION of consent with order)					
Provider Signature	Print Name		Date	Time	
Another brand of drug, identical in form and content, may be dispensed unles		s checked 🗆	) Order ex	pires in 12 months**	
Patient Identification - Always Attach Patient Label		Pre-pri	nted Order		
Name:		RABIE	S VACCINE ORI	DERS	
MRN #:					
CSN #:		N.A. 1-			
Age / Sex and Gender:		wult	iCare 🚹	62-1352-3 (Rev. 9/24)	

Age / Sex and	d Gender:
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