

Complete the following form to request free rabies vaccines and/or Human Rabies Immunoglobulin (RIG). The information collected is used to monitor vaccine use and stock availability, and for disease surveillance. Please advise your patient that this information is being provided to the department (as required by the Health Records Act 2001). Commonwealth and State privacy legislation does not negate the responsibility to provide the information requested on this form.

**Instructions**

1. Assess the patient's wound and determine the category of exposure as per the algorithm in the Immunisation Handbook (<https://immunisationhandbook.health.gov.au/vaccine-preventable-diseases/rabies-and-other-lyssaviruses>)
2. If the exposure was caused by a bat in Australia and the bat is accessible for testing, you may contact the department on 1300 651 160 to arrange testing of the bat
3. Return this form to the Immunisation Section by email to **immunisation@health.vic.gov.au**. Please note:
  - Forms will be processed during business hours (9am to 5pm, Monday to Friday)
  - The Immunisation Section can be contacted by emailing **immunisation@health.vic.gov.au**. Emails received outside of business hours will be actioned the following business day
  - For urgent out-of-hours advice please call **1300 651 160**

**Requesting doctor details**

|                                            |                              |                                                                                                                                                                             |
|--------------------------------------------|------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Name</b>                                |                              | <b>Medicare provider no.</b>                                                                                                                                                |
| <b>Clinic/Health service/Pharmacy name</b> |                              | <b>Department of Health / Onelink account number</b>                                                                                                                        |
| <b>Address</b>                             |                              |                                                                                                                                                                             |
| <b>City</b>                                |                              | <b>Postcode</b>                                                                                                                                                             |
| <b>Telephone</b>                           | <b>Fax</b>                   |                                                                                                                                                                             |
| <b>Date of order</b>                       | <b>Date vaccine required</b> | <b>Reason for order (please select the most appropriate option)</b>                                                                                                         |
|                                            |                              | <input type="checkbox"/> Replacing stock administered<br><input type="checkbox"/> Stock for upcoming patient appointment<br><input type="checkbox"/> Other, specify > _____ |

**Patient details (please answer all questions)**

|                                                                                                                                                                                                                                                                                        |                                                                                                                     |                                     |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|-------------------------------------|
| <b>Last name</b>                                                                                                                                                                                                                                                                       | <b>Country of birth</b>                                                                                             | <b>...year arrived in Australia</b> |
|                                                                                                                                                                                                                                                                                        | <input type="checkbox"/> Australia<br><input type="checkbox"/> Overseas > _____                                     |                                     |
| <b>First name(s)</b>                                                                                                                                                                                                                                                                   | <b>Is the patient immunocompromised</b>                                                                             |                                     |
|                                                                                                                                                                                                                                                                                        | <input type="checkbox"/> Yes, specify > _____<br><input type="checkbox"/> No<br><input type="checkbox"/> Unknown    |                                     |
| <b>Date of birth</b>                                                                                                                                                                                                                                                                   | <b>Sex</b>                                                                                                          |                                     |
|                                                                                                                                                                                                                                                                                        | <input type="checkbox"/> Male<br><input type="checkbox"/> Female<br><input type="checkbox"/> Other, specify > _____ |                                     |
| <b>Residential address</b>                                                                                                                                                                                                                                                             |                                                                                                                     |                                     |
| <b>Suburb/town</b>                                                                                                                                                                                                                                                                     | <b>Postcode</b>                                                                                                     |                                     |
| <b>Preferred telephone number</b>                                                                                                                                                                                                                                                      |                                                                                                                     |                                     |
| <b>Parent/guardian/next of kin name and contact number</b>                                                                                                                                                                                                                             |                                                                                                                     |                                     |
| <b>Interpreter required</b>                                                                                                                                                                                                                                                            |                                                                                                                     |                                     |
| <input type="checkbox"/> Yes, language > _____<br><input type="checkbox"/> No                                                                                                                                                                                                          |                                                                                                                     |                                     |
| <b>Is the patient of Aboriginal or Torres Strait Islander origin</b>                                                                                                                                                                                                                   |                                                                                                                     |                                     |
| <input type="checkbox"/> No<br><input type="checkbox"/> Aboriginal<br><input type="checkbox"/> Torres Strait Islander<br><input type="checkbox"/> Both Aboriginal and Torres Strait Islander<br><input type="checkbox"/> Unknown                                                       |                                                                                                                     |                                     |
| <b>Clinical and exposure information</b>                                                                                                                                                                                                                                               |                                                                                                                     |                                     |
| <b>Date of possible exposure</b>                                                                                                                                                                                                                                                       |                                                                                                                     |                                     |
| <b>Animal that caused the wound/exposure to rabies/ABLV</b>                                                                                                                                                                                                                            |                                                                                                                     |                                     |
| <input type="checkbox"/> Fruit bat/flying fox<br><input type="checkbox"/> Other type of bat (e.g. Microbat)<br><input type="checkbox"/> Dog or canine family<br><input type="checkbox"/> Monkey<br><input type="checkbox"/> Unknown<br><input type="checkbox"/> Other, specify > _____ |                                                                                                                     |                                     |
| <b>Type of animal exposure (select one)</b>                                                                                                                                                                                                                                            |                                                                                                                     |                                     |
| <input type="checkbox"/> Bite<br><input type="checkbox"/> Bite and scratch<br><input type="checkbox"/> Scratch<br><input type="checkbox"/> Lick<br><input type="checkbox"/> Other, specify > _____                                                                                     |                                                                                                                     |                                     |

Form continues over the page

## Clinical and exposure information (continued)

### Location of wound (tick all that apply)

- ☐ Forearm (including hand)  
☐ Arm  
☐ Fingers  
☐ Head/neck  
☐ Lower leg (including foot and toes)  
☐ Thigh  
☐ Torso

Describe wound (abrasion, laceration, puncture, tear, etc.)

Describe wound depth and severity

Date wound was assessed

Wound assessed by

- ☐ General Practitioner  
☐ Emergency Department  
☐ Other, specify below

In what country did the exposure occur

- ☐ Australia  
☐ Overseas, specify >

If the exposure occurred in Indonesia, specify the island where the exposure occurred

- ☐ Bali  
☐ Unknown  
☐ Other, specify >

Did the animal appear to be unwell, or exhibit unusual behaviour

- ☐ Yes, describe >  
☐ No  
☐ Unknown

Was the animal tested for rabies/ABLV

- ☐ Yes  
☐ No  
☐ Unknown

If yes, what was the result of the test?

- ☐ Not yet available  
☐ Inconclusive  
☐ Negative  
☐ Positive  
☐ Other, specify >

Is the patient an expatriate or traveller who has spent prolonged periods (ie. more than a month) in a rabies endemic area

- ☐ Yes  
☐ No  
☐ Unknown

Has the patient been working with mammals in a rabies endemic area

- ☐ Yes  
☐ No  
☐ Unknown

Is the patient from a research laboratory background (ie. is a person who may work with live lyssaviruses)

- ☐ Yes  
☐ No  
☐ Unknown

Is the patient likely to have received bites or scratches from bats in their everyday activities (including bat handlers, veterinarians, wildlife officers, and others who come into direct contact with bats)

- ☐ Yes, specify occupation >  
☐ No  
☐ Unknown

## Post-exposure treatment for the current exposure

Has RIG been administered to the patient

- ☐ No  
☐ Yes > Date administered RIG amount given (no. of vials)

Has rabies vaccine been administered to the patient

- ☐ No  
☐ Yes > Date administered Vaccine doses given

## Recommended post-exposure assessment and treatment

Refer to the Immunisation Handbook for guidance on treatment and categorisation of the exposure:

<https://immunisationhandbook.health.gov.au/vaccine-preventable-diseases/rabies-and-other-lyssaviruses>

Category of exposure

- ☐ Category I  
☐ Category II  
☐ Category III

## Vaccine order information - this section MUST BE COMPLETED to receive your order

### Rabies vaccine:

Day 0, 3, 7, 14 (+D28 if immunocompromised) for Rabies/ABLV  
Post-Exposure Prophylaxis

Number of vials/vaccines needed >

Please note: Hospitals may order 1 dose. Unless special circumstances exist, all remaining doses should be ordered and obtained by the patient's preferred GP clinic.

### Human rabies immunoglobulin:

Recommended dose is 20 IU/kg body weight  
(RIG comes in 2ml vials, each containing 150 IU/ml)

Weight (whole number) kg  
Number of vials/vaccines needed >

Administer one vial per 15kg of the case's body weight

## Rabies vaccination history (for exposures prior to the current exposure)

Has the patient previously received rabies vaccination

- ☐ Unknown  
☐ No  
☐ Yes > How many doses were given Approx. date the last dose was given

Data collection ends here. Thank you

To complete your vaccine order, ensure all sections are completed and email this form to [immunisation@health.vic.gov.au](mailto:immunisation@health.vic.gov.au)