Riverbend Medical Center Regional Infusion Center (RIC)
3377 Riverbend Drive Suite 502/510
Springfield, Oregon 97477
Phone 541-222-6280 Fax 541-349-8006

RABIES VACCINATION (Imovax/ Rabavert) Post-Exposure (v. 05/24/2024)

Diagnosis/Indication (ICD-10): _____

Date of first dose rabies vaccination: _____

Medications:

- Rabies Vaccine 2.5 units intramuscular IM on days 3, 7 and 14 post-exposure. Inject vaccine at anatomical site distant from where immunoglobulin administered. Use deltoid in adults and adolescents; anterolateral thigh in infants and small children.

Nursing communications:

- Patient should have received immunoglobulin and first dose vaccination prior to arriving at RIC. This order set is follow up vaccination.
- Provide patient/ patient support person with CDC Rabies Vaccine Information Sheet

Emergency Medications:

- DiphenhydrAMINE (BENADRYL) 25 to 50 mg IV as needed for mild to moderate drug reactions (flushing, dizziness, headaches, diaphoresis, fever, palpitations, chest discomfort, blood pressure changes (>/= 20 points in SBP), nausea, urticaria, chills, pruritic). Administer 25 mg IV once, if reaction does not resolve in 3 minutes may repeat 25 mg IV dose for a total of 50 mg and contact provider.
- MethylPREDNISolone sodium succinate (Solu-MEDROL) 125 mg IV once as needed for shortness of breath, continued symptoms of mild to moderate drug reaction (flushing, dizziness, headaches, diaphoresis, fever, palpitations, chest discomfort, blood pressure changes (>/= 20 points in SBP), nausea, urticaria, chills, pruritic) that worsen or persist 5 minutes after administration of diphenhydramine (Benadryl). Contact provider if given.
- Epinephrine 0.3 mg IM once for anaphylaxis. If reaction does not resolve in 3 minutes may repeat 0.3 mg IM dose for a total of 0.6 mg. Avoid use of hand, foot, leg veins in elderly patient and those with occlusive vascular disease. Contact provider if given.
- Famotidine (PEPCID) 20 mg IV once as needed for infusion/ allergic reaction.
- May give emergency medications IM if IV route unavailable

Patient name: _____

DOB: _____

Height _____ Weight _____

Provider printed name: _____

Provider signature: _____

Date: _____ Time: _____