FirstHealth OF THE CAROLINAS

7096.08.16150.00 Sunset Date: 7/2024

OP Rabies Series Vaccine Referral

1POREF001

Place Patient Label
Inside This Box

***** This section refers to the entire plan. If individual orders need a different interval, please indicate in each section below*****

Version 7/2021

Date of Infusion: _____

Patient Name: _____

Patient SSN (if available): _____

Insurance Name: _____

Secondary Insurance: _____

Diagnosis Code: _____

Diagnosis Code Description: _____

Lead Physician _____

Date of Birth: _____

Contact Number: _____

Policy Number: _____

Policy Number: _____

Precertification: ☐ Initiated ☐ Complete

Location to be Performed:
☐ Moore Regional Hospital (MRH)
☐ Montgomery Memorial Hospital (MMH)

Interval _____ Day _____ of every _____ month

Minimum Separation _____ days / weeks (circle one)

Next Due Date _____

Duration: ☐ Until discontinued ☐ ____ Treatments
☐ Until _____

Medications	Interval	Duration
☐ rabies vaccine 1 mL 1 mL, intramuscular **Doses to be given on days 3, 7 and 14. First dose given in ED at day 1 of exposure.**	Once	3 treatments

For Scheduling Fax Forms to: (910) 715-1177.

Provider Signature: _____ Date: _____ Time: _____

* May be used as EPIC Downtime Form