RENSIMER & ASSOCIATES/INTERNATIONAL MEDICINE CENTER
RABIES SERVICES INTAKE/ACTION FORM

9230 Katy Fwy Suite 400
Houston, TX 77055

Called Date: _____/_____/_____ Time: _____ AM PM Day: M T W Th F Sat Su

Patient Name: _____ DOB: _____ AGE: _____

CELL#: (____) _____ ☐ Work# ☐ HM#: (____) _____ Email: _____

Address: _____ Zip _____ SSN #: _____

PAYOR: ___INSURANCE ___COMPANY/EMPLOYER ___SELF ___OTHER: _____

REFERRED BY: _____ **PREFERRED APPT. DATE:** _____ TIME: _____

ATTENTION! CALL 713-973-6078 AS SOON AS THIS FORM IS COMPLETED so we can review and then direct you on next steps.

EXPOSURE INFORMATION

Patient Weight: _____ lbs / _____ kg

Geographic Location: _____ Drive Time To Us: _____

Animal Contact: _____ (Date) _____ (Animal Type) Country of Exposure: _____

ANIMAL IN POSSESSION OR RECOVERABLE?: ☐ Y ☐ N Comment: _____

Exposure Type: ☐ Bite ☐ Scratch ☐ Saliva Exposure Site: ☐ Head ☐ Neck ☐ Arm ☐ Leg

☐ Household Bat(s) ☐ Other: _____

Comments: _____

RABIES TREATMENT:

Past Rabies Immunizations: ☐ Y ☐ N Mo: _____ Yr: _____

Recent Treatment with this Animal Exposure: ☐ Y ☐ N

HRIG: ☐ Y ☐ N Date: _____

Vaccines: ☐ Y ☐ N Date: _____ No. of doses: _____

Antibiotics ☐ Y ☐ N

Tetanus Vaccine ☐ Y ☐ N

	HRIG (rabies globulin)	Vaccine	No. of Doses
Date:			
Date:			
Date:			

Immune-Compromised Condition or Medication: Y / N: Describe: _____

Allergy (Major Reaction) To: ☐ Eggs ☐ Chicken ☐ Gelatin ☐ Neomycin ☐ Chlortetracycline ☐ Amphotericin-B ☐ Rabies Vaccine/ HRIG

☐ Other: _____

☐ Describe Reaction: _____

INSURANCE: ☐ Medicare ☐ Blue Cross/Blue Shield ☐ Aetna ☐ United Healthcare ☐Cigna ☐ Humana

☐ Well Care/Texan Plus ☐ Workers Comp. ☐ Other: _____ ☐ **SELF-PAY**

Insured/Policyholder Name: _____ Insured DOB: _____ Relationship to Pt.: _____

Member ID #: _____ Group#: _____

Provider Support 800 Number: _____ Claims Address: _____

END OF PATIENT SECTION

STAFF SECTION

PHYSICIAN: ___ Definitely___ Likely___ Maybe ___ Unlikely ___ Uncertain needs rabies immunization;
IMMEDIATELY give this completed form to **physician/manager.***

RECOMMENDATIONS/ORDERS:

1. Services Payment Manager Recommendations/Physician-NP Orders,

Manager	MD/NP (check box)	
		Insurance
		Insurance for RA Consult Visits Only
		ABx Pharmacy: _____HRIG _____Vaccine

2. Make Patient Appointment ____ Today ____: M Tu W Th F Sat Su ____ Next Week
___ Office ___ Telemedicine

FINAL PATIENT DISPOSITION

__ 1. Patient accepted terms.

__ 2. Patient will see physician, and then consider ABx payment.

__ 3. Patient will see physician and shop HRIG/Vaccine.

__ 4. Patient declined eval/Rx. (will go elsewhere).

**Immediately Contact Practice Manager for Input.

_____MD
Edward Rensimer