DEPARTMENT OF NEUROVIROLOGY

NATIONAL INSTITUTE OF MENTAL HEALTH AND NEUROSCIENCES

BANGALORE 560029

REQUEST FORM FOR RABIES POST VACCINATION ANTIBODY TITRE BY RFFIT*

<table>
<tr><td>Name of the patient/client:</td><td>Age/Sex:</td></tr>
<tr><td colspan="2">Name of Referring doctor and hospital with email ID and mobile number :
(If self-referred, details of Client only to be mentioned below)</td></tr>
<tr><td colspan="2">Complete address:</td></tr>
<tr><td>Email ID</td><td>Contact No.</td></tr>
<tr><td colspan="2">History of Exposure (If applicable)

Date and site(s) of exposure:
WHO Category of exposure (Category I/II/II):
Bitten/Exposed to which animal:
Was Post exposure prophylaxis given: Vaccine only/Vaccine and Rabies Immunoglobulin/No PEP</td></tr>
<tr><td colspan="2">History of most recent vaccination: Pre-exposure/Post exposure:

Name of Vaccine used:</td></tr>
<tr><td>Dates of administration:</td><td>Intramuscular/ Intradermal

If I.M, site of administration</td></tr>
<tr><td colspan="2">Any other past history of vaccination? If Yes, provide details</td></tr>
<tr><td colspan="2">Any other relevant history:</td></tr>
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***RFFIT**: Rapid Fluorescent Focus Inhibition Test