HUMAN RABIES INVESTIGATION FORM

STOP: PRIOR TO CREATING THIS INVESTIGATION, YOU MUST NOTIFY & CONSULT WITH CENTRAL OFFICE (800) 338-8374 (24-HOUR COVERAGE)

BASIC DEMOGRAPHIC DATA

Last Name:_____ First Name:_____ Middle Name:_____

DOB: __ __ / __ __ /__ __ __ __ Age: _____ ☐ years ☐ months Current Sex: ☐ Female ☐ Male ☐ Unknown

Street Address 1:_____ Street Address 2:_____

City:_____ State:_____ Zip Code:_____ County:_____

Home Phone: (__ __ __) - __ __ __ - __ __ __ __ Cell Phone: (__ __ __) - __ __ __ - __ __ __ __ Work Phone: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Unknown

INVESTIGATION SUMMARY

Investigation Start Date: __ __ / __ __ /__ __ __ __ Investigation Status: ☐ Open ☐ Closed Investigator:_____

REPORTING SOURCE

Date of Report: __ __ / __ __ /__ __ __ __ Reporting Source:_____

CLINICAL

Physician's Name:_____ Phone Number: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Was patient hospitalized for this illness? ☐ No ☐ Unknown ☐ Yes If yes: Hospital Name:_____

Admission Date: __ __ / __ __ /__ __ __ __ Discharge Date: __ __ / __ __ /__ __ __ __ Duration of Stay _____ day(s)

Diagnosis Date: __ __ / __ __ /__ __ __ __ Illness Onset Date: __ __ / __ __ /__ __ __ __ Illness End Date: __ __ / __ __ /__ __ __ __

Age at Onset: _____ ☐ days ☐ hours ☐ minutes ☐ months ☐ unknown ☐ weeks ☐ years

Weight: _____lbs _____oz OR _____kg OR ☐ Unknown

Did the patient die from this illness? ☐ No ☐ Unknown ☐ Yes Date of Death: __ __ / __ __ /__ __ __ __

SYMPTOMS

Did the patient have:

Fever: ☐ No ☐ Unknown ☐ Yes (Temp_____) Onset date: __ __ / __ __ /__ __ __ __ Duration (in days): _____

Headache: ☐ No ☐ Unknown ☐ Yes Onset date: __ __ / __ __ /__ __ __ __ Duration (in days): _____

Weakness: ☐ No ☐ Unknown ☐ Yes Onset date: __ __ / __ __ /__ __ __ __ Duration (in days): _____

Discomfort: ☐ No ☐ Unknown ☐ Yes Onset date: __ __ / __ __ /__ __ __ __ Duration (in days): _____

Anxiety: ☐ No ☐ Unknown ☐ Yes Onset date: __ __ / __ __ /__ __ __ __ Duration (in days): _____

Confusion: ☐ No ☐ Unknown ☐ Yes Onset date: __ __ / __ __ /__ __ __ __ Duration (in days): _____

Agitation: ☐ No ☐ Unknown ☐ Yes Onset date: __ __ / __ __ /__ __ __ __ Duration (in days): _____

Delirium: ☐ No ☐ Unknown ☐ Yes Onset date: __ __ / __ __ /__ __ __ __ Duration (in days): _____

Abnormal Behavior: ☐ No ☐ Unknown ☐ Yes Onset date: __ __ / __ __ /__ __ __ __ Duration (in days): _____

Specify abnormal behavior: _____

Insomnia: ☐ No ☐ Unknown ☐ Yes Onset date: __ __ / __ __ /__ __ __ __ Duration (in days): _____

Prickling/Itching at site of scratch or bite? ☐ No ☐ Unknown ☐ Yes Onset date: __ __ / __ __ /__ __ __ __ Duration (in days): _____

Did the patient have encephalomyelitis? ☐ No ☐ Unknown ☐ Yes Onset date: __ __ / __ __ /__ __ __ __ Duration (in days): _____

Did the patient progress to coma or death within 10 days of illness onset? ☐ No ☐ Unknown ☐ Yes

OTHER CLINICAL

Has the patient received pre-exposure prophylaxis (PrEP)?

Has the patient started post-exposure vaccination? ☐ No ☐ Unknown ☐ Yes Date: __ __ / __ __ /__ __ __ __

Has the patient received Rabies immunoglobulin (RIG) post-exposure? ☐ No ☐ Unknown ☐ Yes Date: __ __ / __ __ /__ __ __ __

EPIDEMIOLOGIC

Was the patient exposed to an animal? ☐ No ☐ Unknown ☐ Yes

If yes, what kind of animal? _____

Date of exposure to animal: __ __ / __ __ /__ __ __ __

Was the animal tested? ☐ No ☐ Unknown ☐ Yes If yes, results: _____

Description of Exposure (kiss, bite, scratch, laboratory acquired, organ donation, etc.): _____

Location of Exposure: _____ Sought medical evaluation? _____

Is this patient associated with a day care facility? ☐ No ☐ Unknown ☐ Yes Is this patient a food handler? ☐ No ☐ Unknown ☐ Yes

Is this case part of an outbreak? ☐ No ☐ Unknown ☐ Yes If yes, outbreak name:_____

Case Status: ☐ Confirmed ☐ Not a Case ☐ Probable ☐ Suspect ☐ Unknown MMWR Week: _____ MMWR Year:_____

ADMINISTRATIVE

General Comments:_____

_____

PHA4 SUPERVISOR REVIEW

Date Due: __ __ / __ __ /__ __ __ __ Investigation ready for supervisor review: ☐ Reviewed (Complete) ☐ Reviewed (Incomplete)

Date investigation ready for supervisor review: __ __ / __ __ /__ __ __ __ ☐ Reviewed (Not a case) ☐ Yes

Review comments (completed by supervisor):_____

CONTACT ATTEMPTS

Physician Contact Date(s):

1st Attempt: __ __ / __ __ /__ __ __ __ 2nd Attempt: __ __ / __ __ /__ __ __ __ 3rd Attempt: __ __ / __ __ /__ __ __ __

Patient Contact Date(s):

1st Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐ AM ☐ PM 2nd Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐ AM ☐ PM

3rd Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐ AM ☐ PM

Regular Letter Mailed: __ __ / __ __ /__ __ __ __ Certified Letter Mailed: __ __ / __ __ /__ __ __ __

Was clinical information obtained from the physician or patient? ☐ Yes ☐ No

CASE CLASSIFICATION

1	Did the patient have encephalomyelitis†? †*Rabies encephalomyelitis almost always progresses to coma or death within 10 days of illness onset.*	☐ No ☐ Unknown ☐ Yes
2	Was at least one of the following confirmatory laboratory results demonstrated by a state or federal public health laboratory? ☐ Lyssavirus antigens detected in a clinical specimen† by direct fluorescent antibody test; or ☐ Lyssavirus isolated (in cell culture or lab animal) from saliva or central nervous system tissue; ☐ Lyssavirus antibody in CSF by indirect fluorescent antibody or complete rabies neutralization at 1:5 dilution; ☐ Lyssavirus antibody in serum of unvaccinated person by indirect fluorescent antibody or complete rabies neutralization at 1:5 dilution; **or** ☐ Lyssavirus RNA in saliva, CSF, or tissue usinge reverse transcriptase-polymerase chain reaction (RT-PCR). †*Preferred clinical specimens include brain or the nerves surrounding hair follicles in the nape of the neck.*	☐ No ☐ Unknown ☐ Yes

Confirmed: 1 & 2