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