Rabies (human)

Agency:

Investigator:

Phone number:

FOR STATE USE ONLY
Status: ☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case
Reviewer initials:
Referred to another state:

CASE

Last name:
First and middle name:
Maiden name: Suffix:
Address line:
Zip: City:
State: County:
Phone: ( )- - Type:
Long-term care resident: ☐ Yes ☐ No ☐ Unknown
Facility name:

Date of Birth: / / Estimated? ☐ Age:
Gender: ☐ Female ☐ Male ☐ Other
Pregnant: ☐ Yes ☐ No ☐ Unk Est. delivery date: / /
Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Parent with partner ☐ Widowed
Race: ☐ American Indian or Alaskan Native ☐ Unknown ☐ Black or African American ☐ White ☐ Hawaiian or Pacific Islander ☐ Asian
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown
Parent/Guardian name:
Parent/Guardian phone: ( )- - Type:

EVENT

Diagnosis date: / / Onset date: / /
Event outcome: ☐ Survived this illness ☐ Died from this illness ☐ Died unrelated to this illness ☐ Unknown
Outbreak related: ☐ Yes ☐ No ☐ Unknown
Outbreak name:
Exposure setting:
Epi-linked: ☐ Yes ☐ No ☐ Unk To whom:
Location acquired: ☐ In USA, in reporting state ☐ In USA, outside reporting state ☐ Outside USA ☐ Unknown
State: Country:

Healthcare provider information

Last name:
First name:
Provider title: ☐ ARNP ☐ MD ☐ DO ☐ NP ☐ PA
Facility name:
Address line 1:
Address line 2:
Zip code: City:
State: County:
Phone : ( )- - Type:

LABORATORY FINDINGS

Laboratory: Accession #: Collection date: / /
Date received: / / Specimen source: Result date: / /
Result type: ☐ Preliminary ☐ Final Test type: Result: ☐ Positive ☐ Negative
Organism: Rabies virus Animal species:

Laboratory: Accession #: Collection date: / /
Date received: / / Specimen source: Result date: / /
Result type: ☐ Preliminary ☐ Final Test type: Result: ☐ Positive ☐ Negative
Organism: Rabies virus Animal species:

Laboratory: Accession #: Collection date: / /
Date received: / / Specimen source: Result date: / /
Result type: ☐ Preliminary ☐ Final Test type: Result: ☐ Positive ☐ Negative
Organism: Rabies virus Animal species:

OCCUPATIONS

Interpret 'occupation' very loosely and consider every person to have at least one 'occupation'.

Occupation type: _____ Job title: _____
Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name: _____
Date worked from: / / Address: _____
Date worked to: / / Zip code: _____
Removed from duties: ☐ Yes ☐ No ☐ Unknown City: _____ State: _____ County: _____
Date removed: / / Phone: ( )- - Type:

Handle food: ☐ Yes ☐ No ☐ Unknown
Attend or provide child care: ☐ Yes ☐ No ☐ Unknown
Attend school: ☐ Yes ☐ No ☐ Unknown
Work in a lab setting: ☐ Yes ☐ No ☐ Unknown
Work in a health care setting: ☐ Yes ☐ No ☐ Unknown
Direct patient care duties in lab or health care setting: ☐ Yes ☐ No ☐ Unknown
Health care worker type:

Occupation type: _____ Job title: _____
Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name: _____
Date worked from: / / Address: _____
Date worked to: / / Zip code: _____
Removed from duties: ☐ Yes ☐ No ☐ Unknown City: _____ State: _____ County: _____
Date removed: / / Phone: ( )- - Type:

Handle food: ☐ Yes ☐ No ☐ Unknown
Attend or provide child care: ☐ Yes ☐ No ☐ Unknown
Attend school: ☐ Yes ☐ No ☐ Unknown
Work in a lab setting: ☐ Yes ☐ No ☐ Unknown
Work in a health care setting: ☐ Yes ☐ No ☐ Unknown
Direct patient care duties in lab or health care setting: ☐ Yes ☐ No ☐ Unknown
Health care worker type:

HOSPITALIZATIONS

Was the case hospitalized? ☐ Yes ☐ No ☐ Unknown

Hospital: _____ Isolated at entry: ☐ Yes ☐ No ☐ Unk Isolation type (entry): _____
Admission date: / / Discharge date: / / Days hospitalized: _____
Currently isolated: ☐ Yes ☐ No ☐ Unk Current isolation type:

Hospital: _____ Isolated at entry: ☐ Yes ☐ No ☐ Unk Isolation type (entry): _____
Admission date: / / Discharge date: / / Days hospitalized: _____
Currently isolated: ☐ Yes ☐ No ☐ Unk Current isolation type:

CLINICAL INFO & DIAGNOSIS

Fever: ☐ Yes ☐No ☐ Unk Onset date: / / Duration: Hours/Days Highest known fever: C/F

Other symptoms:

Agitation ☐ Yes ☐No ☐ Unk
Aversion to airflow on face ☐ Yes ☐No ☐ Unk
Aversion to water ☐ Yes ☐No ☐ Unk
Coma ☐ Yes ☐No ☐ Unk
Delirium ☐ Yes ☐No ☐ Unk
Encephalitis ☐ Yes ☐No ☐ Unk
Excitability ☐ Yes ☐No ☐ Unk
Fever ☐ Yes ☐No ☐ Unk
Headache ☐ Yes ☐No ☐ Unk
Malaise ☐ Yes ☐No ☐ Unk
Muscle weakness ☐ Yes ☐No ☐ Unk
Paralysis ☐ Yes ☐No ☐ Unk
Seizures ☐ Yes ☐No ☐ Unk
Sensory changes ☐ Yes ☐No ☐ Unk
Trouble swallowing ☐ Yes ☐No ☐ Unk

Bite present: ☐ Yes ☐No ☐ Unk Bite location:

Neck/head ☐ Yes ☐No ☐ Unk
Upper extremity ☐ Yes ☐No ☐ Unk
Trunk ☐ Yes ☐No ☐ Unk
Lower extremity ☐ Yes ☐No ☐ Unk

Site cleaned at time of event: ☐ Yes ☐No ☐ Unk

TREATMENT

Pre-exposure vaccination

Vaccinated for rabies: ☐ Yes ☐ No ☐ Unknown

Date vaccinated: / /	**Date vaccinated:** / /	**Date vaccinated:** / /
Lot #:	Lot #:	Lot #:
Vaccine type:	Vaccine type:	Vaccine type:
Manufacturer:	Manufacturer:	Manufacturer:
Date vaccinated: / /	**Date vaccinated:** / /	**Date vaccinated:** / /
Lot #:	Lot #:	Lot #:
Vaccine type:	Vaccine type:	Vaccine type:
Manufacturer:	Manufacturer:	Manufacturer:

Number of vaccinations: ____

Post-exposure treatment

Rabies Immune Globulin: ☐ Yes ☐ No ☐ Unknown

Date given: _____

Dose: _____ Unit: _____

Route: _____

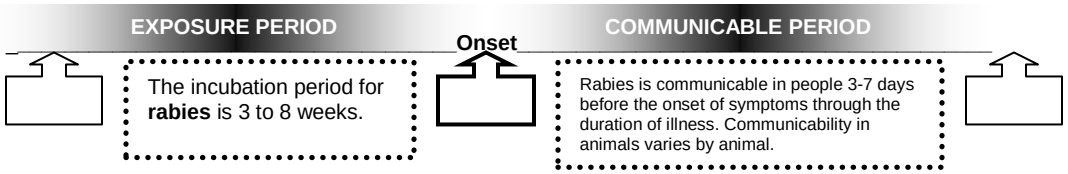
Vaccinated for this exposure: ☐ Yes ☐ No ☐ Unknown

Date vaccinated: / /	**Date vaccinated:** / /	**Date vaccinated:** / /
Lot #:	Lot #:	Lot #:
Vaccine type:	Vaccine type:	Vaccine type:
Manufacturer:	Manufacturer:	Manufacturer:
Date vaccinated: / /	**Date vaccinated:** / /	**Date vaccinated:** / /
Lot #:	Lot #:	Lot #:
Vaccine type:	Vaccine type:	Vaccine type:
Manufacturer:	Manufacturer:	Manufacturer:

Therapeutic medication prescribed: ☐ Yes ☐ No ☐ Unk **List medications:** _____

INFECTION TIMELINE

Enter onset date in dark-line box. Enter dates for start of exposure period and start and end of communicable period.



RISK FACTORS/TRAVEL

Risks 8 weeks prior to onset of symptoms:

Traveled within Iowa? ☐ Yes ☐ No ☐ Unk	City in Iowa: _____	Departure date: / /	Return date: / /
Traveled within U.S.? ☐ Yes ☐ No ☐ Unk	State: _____ City: _____	Departure date: / /	Return date: / /
Traveled outside U.S.? ☐ Yes ☐ No ☐ Unk	Country: _____	Departure date: / /	Return date: / /

Animal contact: ☐ Yes ☐ No ☐ Unknown

Animal:

Bats	☐ Yes ☐ No ☐ Unknown	Goats	☐ Yes ☐ No ☐ Unknown	**Animal type:**	Domestic	☐ Yes	☐No	☐ Unk
Beavers	☐ Yes ☐ No ☐ Unknown	Horses	☐ Yes ☐ No ☐ Unknown		Stray	☐ Yes	☐No	☐ Unk
Cats	☐ Yes ☐ No ☐ Unknown	Pigs	☐ Yes ☐ No ☐ Unknown		Wild	☐ Yes	☐No	☐ Unk
Cattle	☐ Yes ☐ No ☐ Unknown	Raccoon	☐ Yes ☐ No ☐ Unknown		Unknown	☐ Yes	☐No	☐ Unk
Coyote	☐ Yes ☐ No ☐ Unknown	Sheep	☐ Yes ☐ No ☐ Unknown					
Dogs	☐ Yes ☐ No ☐ Unknown	Skunk	☐ Yes ☐ No ☐ Unknown					

Animal breed: _____ **Animal description:** _____

Exposure type:

Bat in house	☐ Yes	☐No	☐ Unk	Contact with saliva	☐ Yes	☐No	☐ Unk
Bat in sleeping area	☐ Yes	☐No	☐ Unk	Scratch	☐ Yes	☐No	☐ Unk
Bat or animal bite	☐ Yes	☐No	☐ Unk	Unknown	☐ Yes	☐No	☐ Unk

Date exposure occurred: / /

Animal vaccination status: ☐ Unvaccinated ☐ Vaccine not current ☐ Vaccinated ☐ Unknown

Animal vaccination date: / /

Was bite provoked: ☐ Yes ☐No ☐ Unk

Exposure site information

Address: _____

City: _____ State: _____

Zip: _____ County: _____

Phone: _____ Type: _____

Animal disposition

Lost to follow-up	☐ Yes	☐No	☐ Unk
Deceased and sent for testing	☐ Yes	☐No	☐ Unk
Deceased and NOT sent for testing	☐ Yes	☐No	☐ Unk
Ill and under quarantine	☐ Yes	☐No	☐ Unk
Ill and NOT under quarantine	☐ Yes	☐No	☐ Unk
Healthy and under quarantine	☐ Yes	☐No	☐ Unk
Healthy after 10 days of quarantine	☐ Yes	☐No	☐ Unk

Animal Owner known: ☐ Yes ☐ No ☐ Unknown

Animal control name/veterinarian: _____

Address: _____

City: _____ State: _____

Zip: _____ County: _____

Phone: ( )- - Type: _____

Animal quarantine site information Facility name: _____

Address: _____

City: _____ State: _____

Zip: _____ County: _____

Phone: ( )- - Type: _____

CONTACTS

Contacts with the same exposures? ☐ Yes ☐ No ☐ Unknown

Contacts with the same exposures as the case or exposures to the case (while case was symptomatic)

Name	DOB	Gender	Address/Phone
	/ /	☐ Male ☐ Female	Zip code: Phone: - -

Relationship to case		List symptoms	Symptom onset date	Is contact a case?
☐ Spouse	☐ Sexual contact		/ /	☐ Yes
☐ Child	☐ Family member (non-household)			☐ No
☐ Sibling	☐ Friend/acquaintance			
☐ Roommate	☐ Contact- work/school/etc			
☐ Parent/ guardian	☐ Unknown/Other			

If this contact is a case create a new event and/or case for this contact.

Name	DOB	Gender	Address/Phone
	/ /	☐ Male ☐ Female	Zip code: Phone: - -

Relationship to case		List symptoms	Symptom onset date	Is contact a case?
☐ Spouse	☐ Sexual contact		/ /	☐ Yes
☐ Child	☐ Family member (non-household)			☐ No
☐ Sibling	☐ Friend/acquaintance			
☐ Roommate	☐ Contact- work/school/etc			
☐ Parent/ guardian	☐ Unknown/Other			

If this contact is a case create a new event and/or case for this contact.

NOTES: _____