

**North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch**



ATTENTION HEALTH CARE PROVIDERS:

Please report relevant clinical findings about this disease event to the local health department.

Durham County Health Department
Communicable Disease Control
414 East Main Street
Durham, NC 27701

Telephone: (919) 560-7600
Fax: (919) 560-7716

**RABIES, HUMAN
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 33**

**ATTENTION Local Health Department Staff: There is no Part 2 Wizard for this disease.
Enter all information from this form into the NC EDSS question packages.**

If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN

NC EDSS LAB RESULTS Verify if lab results for this event are in NC EDSS. If not present, enter results.

Specimen Date	Specimen #	Specimen Source	Type of Test	Test Result(s)	Description (comments)	Result Date	Lab Name—City/State
/ /						/ /	
/ /						/ /	
/ /						/ /	

CLINICAL FINDINGS

Is/was patient symptomatic for this disease? Y N U

If yes, symptom onset date (mm/dd/yyyy): / /

Fever Y N U

Yes, subjective No
 Yes, measured Unknown

How was temperature taken? _____
Highest measured temperature _____
Date of highest measured temperature: / /

Fever onset date (mm/dd/yyyy): / /

Fatigue or malaise or weakness Y N U

Altered mental status Y N U

Patient displayed:

Confusion Agitation
 Delirium Combativeness
 Coma Excitability
 Anxiety/apprehension Hallucinations

Headache Y N U

Encephalitis Y N U

Seizures/convulsions Y N U

Ataxia Y N U

Autonomic instability Y N U

Pain/sensory changes around location of animal bite Y N U

Insomnia Y N U

Hypersalivation Y N U

Aversion to water (hydrophobia) Y N U

Aversion to air on face (aerophobia) Y N U

Cranial nerve or bulbar weakness or paralysis Y N U

Difficulty swallowing (dysphagia) Y N U

Muscle weakness (paresis) Y N U

Muscle paralysis Y N U

Nausea Y N U

Vomiting Y N U

Priapism (persistent erection) Y N U

PREDISPOSING CONDITIONS

Any immunosuppressive conditions? Y N U

Specify: _____

Injury/Wound/Break in skin Y N U

Recent/Acute injury(ies) or wound(s) Y N U

Date (mm/dd/yyyy): / /

Anatomic site _____
Circumstances _____

Principal wound type:

Animal bite
 Other (e.g. with cancer)
 Unknown

HOSPITALIZATION INFORMATION

Was patient hospitalized for this illness >24 hours? Y N U

Hospital name: _____
City, State: _____
Hospital contact name: _____
Telephone: (____) ____ - _____
Admit date (mm/dd/yyyy): / /

Discharge date (mm/dd/yyyy): / /

CLINICAL OUTCOMES

Discharge/Final diagnosis: _____

Survived? Y N U

Died? Y N U

Died from this illness? Y N U

Date of death (mm/dd/yyyy): / /

Autopsy performed? Y N U

Facility where autopsy was performed _____

Patient autopsied in NC? Y N U

County of autopsy: _____

Source of death information:

Death certificate
 Autopsy report final conclusion
 Hospital/physician discharge
 Other

Date of death (mm/dd/yyyy): / /

NOTE: The death certificate, autopsy report, hospital/physician discharge summary, and/or other documentation should be attached.

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
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TREATMENT

Was rabies post-exposure prophylaxis recommended? Y N U
 By whom:
 Public health veterinarian
 Public health physician
 Public health nurse
 Private healthcare provider
 Other
 Unknown

Was rabies post-exposure prophylaxis (PEP) given? Y N U
 Date PEP initiated (mm/dd/yyyy): ____/____/____

Patient previously vaccinated Y N U
 Date vaccinated (mm/dd/yyyy): ____/____/____
 Specify type of PEP:
 Human rabies immune globulin (RIG) and 5 vaccines
 2 vaccines (booster)
 Unknown

Continuing vaccinations begun in another county/state? Y N U

Who supplied PEP? (check all that apply)
 State HD
 LHD
 Private MD
 Other
 Unknown

Who administered PEP? (check all that apply)
 LHD
 Private MD
 Other
 Unknown

Did patient sign a consent/declination form for rabies PEP? Y N U

Did the patient receive medical care for this illness? Y N U
 Specify level(s) of care (check all that apply):
 Outpatient
 Emergency department
 Inpatient
 ICU
 Other
 Unknown

Did the patient require supplemental oxygen? Y N U

Did the patient require mechanical ventilation? Y N U

TRAVEL & IMMIGRATION

The patient is:
 Resident of NC
 Resident of another state or US territory
 None of the above

Did patient have a travel history during the 3-8 weeks prior to onset of symptoms? Y N U
 List travel dates and destinations:
 From ____/____/____ to ____/____/____

Does patient know anyone else with similar symptom(s) who had the same or similar travel history? Y N U
 List persons and contact information:

OTHER EXPOSURE INFORMATION

Does the patient know anyone else with similar symptoms? Y N U
 Specify _____

Has the patient ever served in the U.S. military? Y N U
 If yes, dates of service:
 From _____ to _____

HEALTH CARE FACILITY AND BLOOD & BODY FLUID EXPOSURE RISKS

During the 3-8 weeks prior to onset of symptoms, did the patient have blood or body fluid exposures? Y N U

Transplant recipient (tissue / organ / bone / bone marrow)
 Date received (mm/dd/yyyy): ____/____/____
 Type of donation / transplant _____
 Provider name _____
 Contact name at facility _____
 Facility name _____
 City _____ State _____
 Country _____

OUTDOOR EXPOSURE

During the 3-8 weeks prior to onset of symptoms, did the patient participate in any outdoor activities? Y N U
 If yes, specify and give details:

Was patient exposed to wild animals? .. Y N U
 If yes, specify and give details:

Did patient sleep outside in open? .. Y N U
 If yes, specify and give details:

Did patient sleep in tent or cabin? ... Y N U
 If yes, specify and give details:

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
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ANIMAL EXPOSURE

During the 3-8 weeks prior to onset of symptoms, did the patient have exposure to animals (includes animal tissues, animal products, or animal excreta)? Y N U

Household pets? Y N U

Specify pet(s) _____
 Was pet vaccinated for rabies? Y N U
 Was pet sick? Y N U
 Was pet free-ranging? Y N U

Did patient own, work at, or visit a pet store, animal shelter, and/or animal breeder/wholesaler/distributor? Y N U

Specify:
 Owned
 Worked
 Visited

Business name _____
 Street address _____
 City _____
 State _____ Zip code _____
 Exposed on (mm/dd/yyyy): ___/___/___
 Until (mm/dd/yyyy): ___/___/___
 Frequency
 Once
 Multiple times within this time period
 Daily

Did the patient handle any animals? Y N U

Species: _____
 Did it/they appear sick?..... Y N U

Did patient work with animal importation? Y N U

Business address _____
 City _____
 State _____ Zip code _____
 Species _____
 Country of origin _____
 Shipping port of origin (if known) _____

Did patient / household contact work at, live on, or visit a farm, ranch, or dairy? Y N U

Specify:
 Worked
 Lived on
 Lived with someone who worked/visited
 Visited

Farm/ranch/dairy name _____
 Street address _____
 City _____
 State _____ Zip code _____
 County _____
 Telephone (____) _____
 Exposed on (mm/dd/yyyy): ___/___/___
 Until (mm/dd/yyyy): ___/___/___
 Frequency
 Once
 Multiple times within this time period
 Daily

Was patient exposed to animals associated with agriculture (domestic/semi-domestic animals)? Y N U

Specify animal(s): _____

 Exposed on (mm/dd/yyyy): ___/___/___
 Until (mm/dd/yyyy): ___/___/___
 Frequency:
 Once
 Multiple times within this time period
 Daily

Did the patient work at or visit a fair with livestock or a petting zoo? Y N U

Visited or worked?
 Visited Worked

Specify contact/exposure to agricultural livestock
 Cattle Sheep
 Horses Swine
 Goats Other _____

Fair/petting zoo name _____
 Street address _____
 City _____
 State _____ Zip code _____
 County _____
 Telephone (____) _____

Did the patient work at or visit a zoo, zoological park, or aquarium? Y N U

Visited or worked?
 Visited Worked

Specify contact/exposure to any agricultural livestock present at facility:
 Cattle Sheep
 Horses Swine
 Goats Other _____

Zoo or Aquarium name _____
 Street address _____
 City _____
 State _____ Zip code _____
 County _____
 Telephone (____) _____

Did patient work in a veterinary practice or animal laboratory, animal research setting, biomedical laboratory, or an animal diagnostic laboratory? Y N U

Which type of work setting?
 Animal diagnostic (pathology) laboratory
 Animal laboratory/animal research
 Biomedical laboratory
 Research involving animals
 Veterinary medical practice

Name of facility _____
 Street address _____
 City _____
 State _____ Zip code _____
 County _____
 Telephone (____) _____

Specify species: _____

Did patient work with rabies vaccine production? Y N U

Did patient necropsy animals? Y N U

Specify species: _____

RABIES EXPOSURE

During the 3-8 weeks prior to onset of symptoms, was the patient known to be or potentially exposed to a rabid animal? Y N U

If yes, type of exposure
 Bite (any penetration of the skin by teeth)
 Non-bite (contamination of open wound, abrasion, mucous membrane or scratch with saliva or other potentially infectious material, such as nervous tissue)
 Cryptic / presumed (no known exposure to saliva; i.e. bat found in house, bat found in sleeping area, aerosol exposure such as caves)
 Unknown

On (mm/dd/yyyy): ___/___/___
 Until (mm/dd/yyyy): ___/___/___
 Frequency
 Once
 Multiple times within this time period
 Daily

Circumstances of exposure _____

Location of wound on body (anatomic site: hand, arm, leg, etc.) _____

Was wound cleaned? Y N U

Sought medical attention & treatment? Y N U

Exposure location (where exposure occurred)
 In North Carolina
 County _____
 Outside North Carolina, but in US
 State _____
 Outside US
 Country _____

Was the animal wild? Y N U

Specify animal _____
 Unknown animal species

Was the animal captured for testing? ... Y N U

If yes, DFA result
 Positive Negative Inconclusive

Laboratory name _____
 Street address _____
 City _____ State _____
 Zip code _____
 Telephone (____) _____

Was the animal a domestic animal or pet? Y N U

Specify animal _____

Was the animal vaccinated? Y N U

Date of animals last rabies vaccine: ___/___/___
 Total number of doses _____

Is animal undergoing 10-day confinement? Y N U

Date entered 10-day confinement: ___/___/___
 Is 10-day confinement complete? Y N U
 Date completed 10-day confinement: ___/___/___

Was animal dead or alive at time of exposure?
 Status unknown Dead Alive

Did the animal appear sick or exhibit abnormal behavior? Y N U

Describe behavior(s)
 Lethargic
 Aggressive
 Salivating
 Staggering or have abnormal gait

Did animal attack animal(s) or person(s)? Y N U

If yes, was the animal provoked? Y N U

Animal-related notes:

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CASE INTERVIEWS/INVESTIGATIONS

Was the patient interviewed? Y N U
 Date of interview (mm/dd/yyyy): ____/____/____
 Were interviews conducted with others? Y N U
 Who was interviewed?
 Were health care providers consulted? Y N U
 Who was consulted?
 Medical records reviewed (including telephone review with provider/office staff)? Y N U
 Specify reason if medical records were not reviewed:
 Notes on medical record verification:

GEOGRAPHICAL SITE OF EXPOSURE

In what geographic location was the patient MOST LIKELY exposed?
 Specify location:
 In NC
 City _____
 County _____
 Outside NC, but within US
 City _____
 State _____
 County _____
 Outside US
 City _____
 Country _____
 Unknown
 Is the patient part of an outbreak of this disease? Y N

Notes:

VACCINE

Has patient/contact ever received rabies vaccine Y N U
 Known vaccine type, specify _____
 Unknown vaccine type
 Rabies Immune Globulin (RIG)
 Number of doses received? _____
 Date(s) of doses: _____
 How many days prior to illness onset was vaccine received?
 Fewer than 14 days 14 days or more
 Prescribing healthcare provider name _____
 Prescribing healthcare provider telephone (____) _____
 Was vaccination pre-exposure or post-exposure?
 Pre-exposure Post-exposure
 Source of vaccine information:
 Patient's or Parent's verbal report
 Physician
 Medical record (Note: Any vaccine on a medical record should be recorded in the NCIR)
 Certificate of immunization record (Note: Any vaccine on a certificate of immunization should be recorded in the NCIR)
 Patient vaccine record
 School record
 Other, specify: _____
 Unknown

Rabies, human

1997 CDC Case Definition

Clinical description

Rabies is an acute encephalomyelitis that almost always progresses to coma or death within 10 days after the first symptom.

Laboratory criteria for diagnosis

- Detection by direct fluorescent antibody of viral antigens in a clinical specimen (preferably the brain or the nerves surrounding hair follicles in the nape of the neck), or
- Isolation (in cell culture or in a laboratory animal) of rabies virus from saliva, cerebrospinal fluid (CSF), or central nervous system tissue, or
- Identification of a rabies-neutralizing antibody titer greater than or equal to 5 (complete neutralization) in the serum or CSF of an unvaccinated person.

Case classification

Confirmed: a clinically compatible case that is laboratory confirmed

Comment

Laboratory confirmation by all of the above methods is strongly recommended.