



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

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

Medical provider completing clinical component of surveillance form: Name/Title: _____ Telephone: (____) _____ - _____ Fax: (____) _____ - _____ Date completed ____/____/____	LHD CD nurse/designee completing form for submission to DPH: Name/Title (print): _____ Telephone: (____) _____ - _____ Date completed ____/____/____ LHD CD nurse/designee signature _____
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PERIOD OF INTEREST
 7 years prior to the onset of illness
 (usually 3–8 weeks)

GENERAL DIAGNOSTIC INFORMATION

Is/was patient symptomatic?..... Y N U

Date of illness onset (mm/dd/yyyy): ____/____/____

Diagnosis by health care provider or LHD (mm/dd/yyyy): ____/____/____

Patient's health care provider for this illness _____

Name of provider's practice or facility _____

Telephone number for health care provider (____) _____

LOCAL HEALTH DEPARTMENT USE ONLY

Check one:
 Case definition is met.
 (Complete Part 1 and Part 2 and submit to state)
 Case definition is not met.
 (Complete Part 2 only and submit to state)

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

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

CLINICAL FINDINGS

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

REASON FOR TESTING

Why was the patient tested for this condition?
 Symptomatic of disease
 Screening of asymptomatic person with reported risk factor(s)
 Exposed to organism causing this disease (asymptomatic)
 Household / close contact to a person reported with this disease
 Other, specify _____
 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): ____/____/____
 ICU admission? Y N U

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

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? 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:

HEALTH CARE FACILITY AND BLOOD & BODY FLUID EXPOSURE RISKS

During the 3-8 weeks prior to onset has the patient had any blood or body fluid exposures?

Emergency Department (not hospitalized)

Visit/admit date (mm/dd/yyyy): ____/____/____

Facility name _____

Was facility notified regarding ill patient? Y N U N/A

Hospitalized

Visit/admit date (mm/dd/yyyy): ____/____/____

Has patient been discharged? Y N U

Facility name _____

Was facility notified regarding ill patient? Y N U N/A

Long term care facility - resident (e.g. nursing home, rest home, rehab)

Visit/admit date (mm/dd/yyyy): ____/____/____

Has patient been discharged? Y N U

Facility name _____

City _____ State _____

Country _____

Was facility notified regarding ill patient? Y N U N/A

Outpatient facility - patient (e.g. urgent care, clinic, physician office)

Visit/admit date (mm/dd/yyyy): ____/____/____

Facility name _____

City _____ State _____

Country _____

Was facility notified regarding ill patient? Y N U N/A

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 _____

Visitor to health care setting

Visit/admit date (mm/dd/yyyy): ____/____/____

Until date: ____/____/____

Frequency

Once

Multiple times within this time period

Daily

Facility name _____

City _____ State _____

Country _____

Was facility notified regarding ill patient? Y N U N/A

Worked or volunteered in health care or clinical setting

No

Unknown

BEHAVIORAL RISK & CONGREGATE LIVING

In what setting was the patient most likely exposed?

Restaurant Place of Worship

Home Outdoors, including woods or wilderness

Work Athletics

Child Care Farm

School Pool or spa

University/College Pond, lake, river or other body of water

Camp Hotel / motel

Doctor's office/ Outpatient clinic Social gathering, other than listed above

Hospital In-patient Travel conveyance (airplane, ship, etc.)

Hospital Emergency Department International

Laboratory Community

Long-term care facility /Rest Home Other (specify) _____

Military Prison/Jail/Detention Center Unknown

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 _____

OUTDOOR ACTIVITIES

During the 3-8 weeks prior to onset, 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:

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ANIMALS

During the 3-8 weeks prior to onset, 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 or aviculture (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

Horses

Goats

Sheep

Swine

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

Horses

Goats

Sheep

Swine

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 vaccines for zoonotic agents? Y N U

Specify vaccine(s):

Brucella vaccine (parenteral or mucous membrane)

Other _____

Did patient necropsy animals? Y N U

Specify species: _____

Did patient work with zoonotic agents? Y N U

Specify agent(s): _____

RABIES

During the 3-8 weeks prior to onset, 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

Seek 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 suspected of being part of a common source outbreak? Y N U
Notes:

VACCINE

Has patient/contact ever received vaccine for this disease? 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

DIAGNOSTIC TESTING

Give details below.

Collection Date	Result Date	Type of Test	Specimen Source	Results (include serogroup/type)	Reference Range	Lab Name/City/State
/ /	/ /					
/ /	/ /					
/ /	/ /					

1997 CDC/CSTE 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