# 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: _____

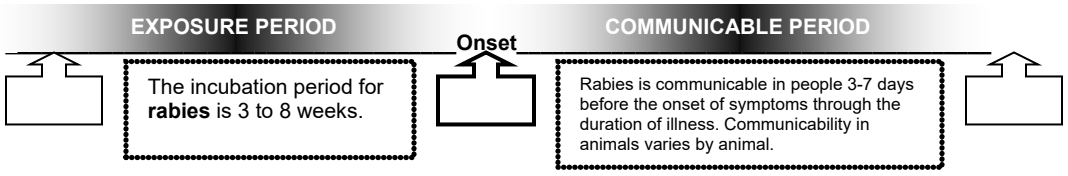
**Vaccinated for this exposure:** ☐ Yes ☐ No ☐ Unknown

| | | |
|---|---|---|
| **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: _____