



Rabies, Human

County _____

Case name (last, first) _____

Birth date ___/___/___ Age at symptom onset _____ Years Months

Alternate name _____

Phone _____ Email _____

Address type Home Mailing Other Temporary Work

Street address _____

City/State/Zip/County _____

Residence type (incl. Homeless) _____ WA resident Yes No

ADMINISTRATIVE

Investigator _____ LHM Case ID (optional) _____

LHM notification date ___/___/___

Classification

Classification pending Confirmed Investigation in progress Not reportable Probable Ruled out Suspect

Investigation status

Complete Complete – not reportable to DOH Unable to complete Reason _____ In progress

Dates: **Investigation start** ___/___/___ Investigation complete ___/___/___ Record complete ___/___/___ **Case complete** ___/___/___

REPORT SOURCE

Initial report source _____ LHM _____

Reporter organization _____

Reporter name _____ Reporter phone _____

All reporting sources (list all that apply)

DEMOGRAPHICS

Sex at birth: Female Male Other Unknown

Do you consider yourself (your child) Hispanic, Latino/a, or Latinx?

Ethnicity Hispanic, Latino/a, Latinx Non-Hispanic, Latino/a, Latinx Patient declined to respond Unknown

What race or races do you consider yourself (your child)? You can be as broad or specific as you'd like (check all responses):

Race Amer Ind/AK Native (*specify:* Amer Ind **and/or** AK Native) Asian Black or African American Native HI/Pacific Islander (*specify:* Native HI **and/or** Pacific Islander) White Patient declined to respond Unk

Additional race information:

Afghan Afro-Caribbean Arab Asian Indian Bamar/Burman/Burmese Bangladeshi Bhutanese

Central American Cham Chicano/a or Chicanx Chinese Congolese Cuban Dominican Egyptian

Eritrean Ethiopian Fijian Filipino First Nations Guamanian or Chamorro Hmong/Mong

Indigenous-Latino/a or Indigenous-Latinx Indonesian Iranian Iraqi Japanese Jordanian Karen

Kenyan Khmer/Cambodian Korean Kuwaiti Lao Lebanese Malaysian Marshallese Mestizo

Mexican/Mexican American Middle Eastern Mien Moroccan Nepalese North African Oromo

Pakistani Puerto Rican Romanian/Rumanian Russian Samoan Saudi Arabian Somali

South African South American Syrian Taiwanese Thai Tongan Ugandan Ukrainian

Vietnamese Yemeni Other: _____

What is your (your child's) preferred language? Check one:

Amharic Arabic Balochi/Baluchi Burmese Cantonese Chinese (unspecified) Chamorro Chuukese

Dari English Farsi/Persian Fijian Filipino/Pilipino French German Hindi Hmong Japanese

Karen Khmer/Cambodian Kinyarwanda Korean Kosraean Lao Mandarin Marshallese Mixteco

Nepali Oromo Panjabi/Punjabi Pashto Portuguese Romanian/Rumanian Russian Samoan

Sign languages Somali Spanish/Castilian Swahili/Kiswahili Tagalog Tamil Telugu Thai Tigrinya

Ukrainian Urdu Vietnamese Other language: _____ Patient declined to respond Unknown

Interpreter needed Yes No Unk

EMPLOYMENT AND SCHOOL

Employed Yes No Unk Occupation _____ Industry _____

Employer _____ Work site _____ City _____

Student/Day care Yes No Unk

Type of school Preschool/day care K-12 College Graduate School Vocational Online Other

School name _____ School address _____

City/State/County _____ Zip _____ Phone number _____ Teacher's name _____

COMMUNICATIONS

Primary HCP name _____ Phone _____

OK to talk to patient (If Later, provide date) Yes Later ___/___/___ Never

Date of interview attempt ___/___/___ Complete Partial Unable to reach Patient could not be interviewed

Alternate contact: Parent/Guardian Spouse/Partner Friend Other _____

Name _____ Phone _____

Outbreak related Yes No LHJ Cluster ID _____ Cluster Name _____

CLINICAL INFORMATION

Complainant ill Yes No Unk Symptom Onset ___/___/___ Derived Diagnosis date ___/___/___

Residence at time of onset _____

Illness duration _____ Days Weeks Months Years Illness is still ongoing Yes No Unk

Clinical Features

Y N Unk

Any fever, subjective or measured Temp measured? Yes No Highest measured temp _____°F

Paresthesias or pain at the wound site

Dysphagia

Painful muscle spasms

Ascending flaccid paralysis

Encephalitis or encephalomyelitis

Agitation or combativeness

Anxiety or apprehension

Confusion

Hallucination

Hydrophobia or aerophobia

Hypersalivation

Priapism

Autonomic instability

Y N Unk

Seizure new with disease

Coma Onset date ___/___/___

Healthcare record contains diagnosis of rabies

Vaccination

Vaccine information available Yes No

Date of vaccine administration ___/___/___ Vaccine administered (Type) _____

Vaccine lot number _____ Administering provider _____

Hospitalization

Y N Unk

Hospitalized at least overnight for this illness Facility name _____

Hospital admission date ___/___/___ Discharge ___/___/___ HRN _____

Disposition Another acute care hospital Facility name _____

Died in hospital

Long term acute care facility Facility name _____

Long term care facility Facility name _____

Non-healthcare (home) Unk Other _____

Admitted to ICU Date admitted to ICU ___/___/___ Date discharged from ICU ___/___/___

Mechanical ventilation or intubation required

Still hospitalized As of ___/___/___

Y N Unk

Died of this illness Death date ___/___/___ *Please fill in the death date information on the Person Screen*

Autopsy performed

Death certificate lists disease as a cause of death or a significant contributing condition

Location of death Outside of hospital (e.g., home or in transit to the hospital) Emergency department (ED)

Inpatient ward ICU Other _____

RISK AND RESPONSE

Travel

	Setting 1	Setting 2	Setting 3
Travel out of:	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____
Destination name	_____	_____	_____
Start and end dates	____/____/____ to ____/____/____	____/____/____ to ____/____/____	____/____/____ to ____/____/____

Risk and Exposure Information

Y N Unk

Is case a recent foreign arrival (e.g. immigrant, refugee, adoptee, visitor) Country _____
 Animal contact/control information known
 Animal control contact name _____ Phone _____
 Animal owner or location (e.g., park) name _____
 Owner address _____ Phone _____
 Veterinarian name _____ Clinic name _____
 Clinic address _____ Phone _____
 Animal vaccination history known Status Vax current Never vaccinated Vax not current Unk
 Date of last rabies vaccine (mm/yyyy) ____/____/____ Total number of rabies doses _____
 Recent suspicious animal exposure Date ____/____/____ City _____ State _____
 Species Dog Cat Raccoon Skunk Fox Bat Other _____
 Type of exposure Bite Scratch Contact only No known exposure Unk
 Other suspicious animal exposure Date ____/____/____ City _____ State _____
 Species Dog Cat Raccoon Skunk Fox Bat Other _____
 Type of exposure Bite Scratch Contact only No known exposure Unk
 (Potential) Occupational exposure

Exposure and Transmission Summary

Likely geographic region of exposure In Washington – county _____ Other state _____
 Not in US - country _____ Unk
 International travel related During entire exposure period During part of exposure period No international travel
Suspected exposure type Animal related Person to person Blood products Unk Other _____
 Describe _____
 Suspected exposure setting Daycare/Childcare School (not college) Doctor's office Hospital ward Hospital ER
 Hospital outpatient facility Home Work College Military Correctional facility Place of worship
 Laboratory Long term care facility Homeless/shelter International travel Out of state travel Transit
 Social event Large public gathering Restaurant Hotel/motel/hostel Other _____
 Describe _____
 Exposure summary _____

Suspected transmission type Person to person Blood products Unk Other _____
 Describe _____
 Suspected transmission setting Daycare/Childcare School (not college) Doctor's office Hospital ward
 Hospital ER Hospital outpatient facility Home Work College Military Correctional facility
 Place of worship Laboratory Long term care facility Homeless/shelter International travel
 Out of state travel Transit Social event Large public gathering Restaurant Hotel/motel/hostel
 Other _____
 Describe _____

Public Health Interventions/Actions

Y N Unk

PEP given to contacts of the case
 Number health care _____
 Number household _____
 Number other _____
 Letter sent Date ____/____/____ Batch date ____/____/____

TRANSMISSION TRACKING

Visited, attended, employed, or volunteered at any public settings while contagious Yes No Unk

Settings and details (check all that apply)

- Day care School Airport Hotel/Motel/Hostel Transit Health care Home Work College
 Military Correctional facility Place of worship International travel Out of state travel LTCF
 Homeless/shelter Social event Large public gathering Restaurant Other

	Setting 1	Setting 2	Setting 3	Setting 4
Setting Type (as checked above)				
Facility Name				
Start Date	__/__/__	__/__/__	__/__/__	__/__/__
End Date	__/__/__	__/__/__	__/__/__	__/__/__
Time of Arrival				
Time of Departure				
Number of people potentially exposed				
Details (hotel room #, HC type, transit info, etc.)				
Contact information available for setting (who will manage exposures or disease control for setting)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk
Is a list of contacts known?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk

If list of contacts is known, please fill out Contact Tracing Form Question Package

TREATMENT

Y N Unk

- PEP recommended after exposure
 PEP completed after exposure
 PEP received after exposure Prompt would care RIG Vaccine
 Did patient receive treatment
 Specify medication _____ Antiviral Other
 Number of days actually taken _____ Treatment start date __/__/__ Treatment end date __/__/__

NOTES

LAB RESULTS

Lab report information

Lab report reviewed – LHJ

WDRS user-entered lab report note

Submitter _____
 Performing lab for entire report _____
 Referring lab _____

Specimen
Specimen identifier/accession number _____
Specimen collection date __/__/__ **Specimen received date** __/__/__

WDRS specimen type _____
 WDRS specimen source site _____
 WDRS specimen reject reason _____

Test performed and result
WDRS test performed _____
WDRS test result, coded _____
 WDRS test result, comparator _____
WDRS result, numeric only (enter only if given, including as necessary **Comparator** and **Unit of measure**) _____
 WDRS unit of measure _____

Test method _____

WDRS interpretation code _____

Test result – Other, specify _____

WDRS result summary Positive Negative Indeterminate Equivocal Test not performed Pending

Test result status Final results; Can only be changed with a corrected result

Preliminary results

Record coming over is a correction and thus replaces a final result

Results cannot be obtained for this observation

Specimen in lab; results pending

Result date ____/____/____

Upload document

Ordering Provider

WDRS ordering provider _____

Ordering facility

WDRS ordering facility name _____

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