



# Suspected Rabies Exposure

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 \_\_\_\_\_ LHJ Case ID (optional) \_\_\_\_\_  
 LHJ 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** \_\_\_\_\_ LHJ \_\_\_\_\_  
 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**

Date of exposure \_\_\_/\_\_\_/\_\_\_

**Clinical Features**

**Y N Unk**

- Public health agency recommends or concurs with recommendation for rabies post-exposure prophylaxis**  
   **Rabies post-exposure prophylaxis given by health care provider but public health does not know circumstances and is unable to perform risk assessment**

**Predisposing Conditions**

**Y N Unk**

- Immunosuppressive therapy or condition, or disease** Specify \_\_\_\_\_

**Vaccination**

**Y N Unk**

- Patient ever received rabies-containing vaccine prior to exposure** Total number of doses prior to exposure \_\_\_\_\_

Vaccine information available  Yes  No

Date of vaccine administration \_\_\_/\_\_\_/\_\_\_ Vaccine administered (Type) \_\_\_\_\_

Vaccine lot number \_\_\_\_\_ Administering provider \_\_\_\_\_

Information source  Washington Immunization Information System (WIIS) WIIS ID number \_\_\_\_\_

Medical record  Patient vaccination card  Verbal only/no documentation  Other state IIS

Date of vaccine administration \_\_\_/\_\_\_/\_\_\_ Vaccine administered (Type) \_\_\_\_\_

Vaccine lot number \_\_\_\_\_ Administering provider \_\_\_\_\_

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Vaccine lot number \_\_\_\_\_ Administering provider \_\_\_\_\_

Information source  Washington Immunization Information System (WIIS) WIIS ID number \_\_\_\_\_

Medical record  Patient vaccination card  Verbal only/no documentation  Other state IIS

- Tetanus vaccine in the last 5 years

**Clinical Testing**

**Y N Unk**

- Human exposed to animal that tests positive for rabies** Date animal submitted for testing \_\_\_/\_\_\_/\_\_\_

Result date \_\_\_/\_\_\_/\_\_\_ Lab submitted to \_\_\_\_\_

**Hospitalization**

**Y N Unk**

- Hospitalized at least overnight for this illness

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

**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**

**Determined by LHJ to be a rabies exposure**

Public exposure to rabid or potentially rabid animal

**Type of animal**  Bat  Cat  Dog  Ferret  Raccoon  Unk  Other \_\_\_\_\_

**Exposure type**  Bite  Saliva  Scratch  Bare skin contact  Bat in sleeping area  Unk  
 Other \_\_\_\_\_

**Animal status**  Domestic  Stray  Wild  Unk  Other \_\_\_\_\_

Animal description \_\_\_\_\_ Animal name \_\_\_\_\_ Breed \_\_\_\_\_

Animal disposition  Sent for testing  Under observation  Healthy after 10 day observation  Lost to follow-up  
 Other \_\_\_\_\_

*If "Under observation" or "Healthy after 10 day observation"*

Quarantine site address \_\_\_\_\_

Phone \_\_\_\_\_ Contact name \_\_\_\_\_

**Y N Unk**

Animal control involved

Contact name \_\_\_\_\_ Phone \_\_\_\_\_

Animal owner/vet information known

Animal owner or location (e.g. park) name \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Veterinarian name \_\_\_\_\_ Clinic name \_\_\_\_\_

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 \_\_\_\_\_

**Injury or exposure circumstances known**

Anatomic site of injury or wound (e.g., head, arm) \_\_\_\_\_

Circumstance of animal exposure \_\_\_\_\_

**Animal exposure provoked**

Wound cleaned

Others exposed to animal

**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

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 \_\_\_\_\_

**Public Health Interventions/Actions**

**Y N Unk**

- Public notice posted of rabid or potentially rabid animal
- Letter sent Date \_\_\_/\_\_\_/\_\_\_ Batch date \_\_\_/\_\_\_/\_\_\_
- Any other public health action \_\_\_\_\_

**TREATMENT**

**Y N Unk**

- PEP recommended by public health agency
- PEP recommended by health care provider
- Rabies vaccine given**  
*If yes,*  
 Prescribing provider \_\_\_\_\_ Vaccine name \_\_\_\_\_  
 Date of vaccination \_\_\_/\_\_\_/\_\_\_  
 Date of vaccination \_\_\_/\_\_\_/\_\_\_  
 Date of vaccination \_\_\_/\_\_\_/\_\_\_  
 Date of vaccination \_\_\_/\_\_\_/\_\_\_  
*If no or unknown,*  
   Vaccination refused
- Human RIG given**  
*If yes,*  
 Prescribing provider \_\_\_\_\_ Date of administration \_\_\_/\_\_\_/\_\_\_  
*If no or unknown,*  
   RIG refused
- Did case receive full series of PEP  
 Reason full series of PEP not received  Animal tested negative for rabies  Patient declined due to cost  
 Other \_\_\_\_\_

**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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