Washington State Department of Health

Rabies, Human

County

Case name (last, first) _____

Birth date ___/___/___ Sex at birth ☐ F ☐ M ☐ Other 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
☐ Not reportable ☐ Probable ☐ Ruled out ☐ Suspect

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

Investigation start date ___/___/___

Investigation complete date ___/___/___

Case complete date ___/___/___

Outbreak related ☐ Yes ☐ No
LHJ Cluster ID _____Cluster Name _____

DEMOGRAPHICS

Age at symptom onset _____ ☐ Years ☐ Months

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unk

Race (check all that apply) ☐ Unk ☐ Amer Ind/AK Native
☐ Asian ☐ Black/African Amer ☐ Native HI/other PI
☐ White ☐ Other _____

Primary language _____

Interpreter needed ☐ Yes ☐ No ☐ Unk

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 _____

REPORT SOURCE

Initial report source _____
LHJ _____
Reporter organization _____
Reporter name _____
Reporter phone _____

All reporting sources (list all that apply)
_____
_____
_____

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 _____

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 _____ºF
☐	☐	☐	Paresthesias or pain at the would 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

Human Rabies required variables are in **bold.** Answers are: Yes, No, Unknown to case

Case Name _____ LHJ Case ID _____

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:	☐ County/City _____ ☐ State _____ ☐ Country _____ ☐ Other _____	☐ County/City _____ ☐ State _____ ☐ Country _____ ☐ Other _____	☐ County/City _____ ☐ State _____ ☐ Country _____ ☐ 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 _____

Case Name _____ LHJ Case ID _____

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)	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk
Is a list of contacts known?	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ 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 _____