Reset Form

U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL
AND PREVENTION
ATLANTA, GA 30329

Possible Human Rabies—Patient Information

FORM APPROVED
OMB NO. 0920-0728

CDC 55.30 (E), Revised July 2016, CDC Adobe Acrobat 11.0, S508 Electronic Version, August 2016

Please complete as much information as possible and then print form. Please fax a copy of the form to 404-639-1564, Attention - Rabies Duty Officer. A printed copy of this form must also accompany diagnostic specimens and should be sent to:

For questions please call 404-639-1050

Rabies Laboratory
DASH, Bldg 18, Rm SSB218
Centers for Disease Control and Prevention
1600 Clifton Rd NE, Atlanta, GA 30329

Physician contact information (MANDATORY — Indicate person to receive official report of results):

Name: _____ Telephone: _____ Fax: _____ Email: _____

Facility Name: _____ City: _____ State: _____

Submit official report of results to: **Attn:** _____ **Fax:** _____ **Email:** _____

Patient information:

ID/Medical Record #: _____ Date of birth: _____

City: _____ State: _____ Occupation: _____

Gender: ☐ F ☐ M Race: ☐ White ☐ Black ☐ Asian ☐ Other ☐ Unknown Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Exposures (during previous 12 months):

Animal exposure: ☐ No ☐ Yes ☐ Unknown

If yes: Date: _____ City: _____ State: _____ Or, if International Country: _____

Species involved in exposure:

☐ Dog ☐ Bat
☐ Cat ☐ Raccoon

Other species: _____

Type of exposure:

☐ Bite ☐ Nonbite (Saliva contact with open wound or mucous membrane)
☐ Unknown ☐ Nonbite (Neural tissue contact with open wound or mucous membrane)

Other type: _____

Arthropod Contact: ☐ No ☐ Yes _____ Medications (including OTC and herbal): ☐ No ☐ Yes _____

Recent Vaccination(s): ☐ No ☐ Yes _____ Outdoor activity (camping, hiking, etc.): ☐ No ☐ Yes _____

Other pertinent exposures (i.e. day care, head trauma, sick contacts, TB exposures, etc.): _____

Travel - specify location and dates:

Outside U.S. Country: _____ Date: _____ Within U.S. State: _____ Date: _____

Sample collection dates (all four samples are required to provide an antemortem rule out of rabies):

Serum: _____ Saliva: _____ Nuchal skin biopsy: _____ CSF: _____

Please provide the following information about the current illness where applicable:

Date of illness onset: _____ Date of hosp admission: _____ Patient expired? ☐ No ☐ Yes Date of death: _____

Admitting diagnosis: _____

Current differential diagnosis: _____

Initial signs and/or symptoms at presentation: _____

Previous hospitalization / ED visit (for current illness)? ☐ No ☐ Yes Facility: _____ Date: _____

Treatment (specify type and date started):

Rabies immunoglobulin: _____ Date started: _____ Rabies vaccine: _____ Date started: _____

Antiviral agents: _____ Date started: _____ Steroids / IVIG: _____ Date started: _____

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In Intensive Care Unit	☐ No	☐ Yes	Date admitted:		Intubated	☐ No	☐ Yes	Date intubated:			
Fever ≥ 38.0°C (100.4°F)	☐ No	☐ Yes	Date of first fever:		Coma	☐ No	☐ Yes	Date of coma:			
Hydrophobia	☐ No	☐ Yes	Hallucinations	☐ No	☐ Yes	Autonomic instability	☐ No	☐ Yes			
Aerophobia	☐ No	☐ Yes	Priapism or spont. ejaculation	☐ No	☐ Yes	Muscle spasm	☐ No	☐ Yes			
Dysphagia	☐ No	☐ Yes	Paresthesia or localized pain	☐ No	☐ Yes	Confusion or delirium	☐ No	☐ Yes			
Abdominal pain	☐ No	☐ Yes	Hypersalivation	☐ No	☐ Yes	Aphasia or dysarthria	☐ No	☐ Yes			
Chest pain	☐ No	☐ Yes	Agitation or aggression	☐ No	☐ Yes	Anxiety	☐ No	☐ Yes			
Headache	☐ No	☐ Yes	Insomnia	☐ No	☐ Yes	Stiff neck	☐ No	☐ Yes			
Malaise or fatigue	☐ No	☐ Yes	Localized weakness	☐ No	☐ Yes	Ataxia	☐ No	☐ Yes			
Anorexia	☐ No	☐ Yes	Seizures	☐ No	☐ Yes	Nausea or vomiting	☐ No	☐ Yes			
Sore throat	☐ No	☐ Yes	Cough or dyspnea	☐ No	☐ Yes	Photophobia / blurred vision	☐ No	☐ Yes			

Brain CT Date: _____
☐ Normal ☐ Abnormal ☐ Not done
If abnormal:
☐ Temporal lobe ☐ Hydrocephalus
☐ Severe cerebral edema
☐ White matter demyelination
Other: _____

Brain MRI Date: _____
☐ Normal ☐ Abnormal ☐ Not done
If abnormal:
☐ Temporal lobe ☐ Hydrocephalus
☐ Severe cerebral edema
☐ White matter demyelination
Other: _____

EEG Date: _____
☐ Normal ☐ Abnormal ☐ Not done
If abnormal:
☐ Diffuse slowing
☐ Temporal epileptiform activity
☐ PLEDS
Other: _____

Microbiological studies / results:

HSV CSF PCR	☐ NEG	☐ POS	☐ Not done	☐ Pending	Enterovirus CSF PCR	☐ NEG	☐ POS	☐ Not done	☐ Pending
Varicella CSF PCR	☐ NEG	☐ POS	☐ Not done	☐ Pending	CrAg CSF	☐ NEG	☐ POS	☐ Not done	☐ Pending
CMV CSF PCR	☐ NEG	☐ POS	☐ Not done	☐ Pending	VDRL CSF	☐ NEG	☐ POS	☐ Not done	☐ Pending

Arbovirus Panel:	**Not Done**	**Pending**	**Serum IgM(+/-)**	**Serum IgG(+/-)**	**CSF IgM(+/-)**	**CSF IgG(+/-)**
West Nile virus	☐	☐				
St. Louis encephalitis	☐	☐				
Eastern Equine enceph	☐	☐				
Western Equine enceph	☐	☐				
California encephalitis	☐	☐				
La Crosse encephalitis	☐	☐				

Other microbiological studies / results: _____

CSF results:
Date: _____ Protein: _____ Glucose: _____ RBC: _____
WBC: _____ Diff: _____ / _____ / _____ / _____ / _____
(segs / lymph / monos / eos / bands)

CBC results:
Date: _____ WBC: _____ HCT: _____ Platelets: _____
Diff: _____ / _____ / _____ / _____ / _____
(segs / lymph / monos / eos / bands)

Other labs / imaging (list results if abnormal):

Na/K/	☐ Normal	☐ Not done	☐ Abnormal	____ / ____ / ____	Glucose	☐ Normal	☐ Not done	☐ Abnormal	
BUN/Cr	☐ Normal	☐ Not done	☐ Abnormal	_____ / _____	ESR	☐ Normal	☐ Not done	☐ Abnormal	
AST/ALT	☐ Normal	☐ Not done	☐ Abnormal	_____ / _____	ANA	☐ Normal	☐ Not done	☐ Abnormal	
Alk Phos	☐ Normal	☐ Not done	☐ Abnormal	_____	CXR	☐ Normal	☐ Not done	☐ Abnormal	
INR/PTT	☐ Normal	☐ Not done	☐ Abnormal	_____ / _____	Tox screen	☐ Normal	☐ Not done	☐ Abnormal	

Other: _____

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