

**Note to Providers:** Complete as much information as possible on page 1 of this form. Fax this report to the local health department immediately.

### PATIENT DEMOGRAPHICS

<b>Name (last, first):</b> _____ <b>Address (mailing):</b> _____ <b>Address (physical):</b> _____ <b>City/State/Zip:</b> _____ <b>Phone (home):</b> _____ <b>Phone (work/cell):</b> _____ <b>Alternate contact:</b> <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Spouse <input type="checkbox"/> Other <b>Name:</b> _____ <b>Phone:</b> _____		<b>Birth date:</b> __/__/____ <b>Age:</b> ____ <b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unk <b>Ethnicity:</b> <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Unk <b>Race:</b> <input type="checkbox"/> White <input type="checkbox"/> Black/Afr. Amer. <input type="checkbox"/> Asian <input type="checkbox"/> Am. Ind/AK Native <small>(Mark all that apply)</small> <input type="checkbox"/> Native HI/Other PI <input type="checkbox"/> Unk
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### PROVIDER INFORMATION

**Physician:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_  
**Facility:** \_\_\_\_\_ **Address:** \_\_\_\_\_  
**City/State/Zip:** \_\_\_\_\_ **Date reported to health department:** \_\_/\_\_/\_\_\_\_

### BITE/EXPOSURE INFORMATION

<b>Exposure date:</b> __/__/____ <b>Exposure Type</b> <b>Y N U</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bite <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Scratch <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Saliva/CNS tissue contact <b>with fresh* wound</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Saliva/CNS tissue contact with mucous membrane <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bat exposure with no definite bite or scratch <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other (Describe: _____) <small>*Fresh wound=a wound that has bled within past 24 hours</small>	<b>Circumstances of Bite/Exposure</b> <b>Y N U</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bite or scratch caused a break in the skin <b>If yes, where on body (mark all that apply):</b> <input type="checkbox"/> Head/neck/face <input type="checkbox"/> Hand <input type="checkbox"/> Leg <input type="checkbox"/> Torso/chest/back <input type="checkbox"/> Arm <input type="checkbox"/> Foot <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Exposure was provoked <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Animal was behaving abnormally
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### CLINICAL INFORMATION

<b>Hospitalization</b> <b>Y N U</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Patient hospitalized for this exposure If yes, hospital name: _____ Admit date: __/__/____ Discharge date: __/__/____  <b>Death</b> <b>Y N U</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Patient died due to this exposure If yes, date of death: __/__/____  <b>Vaccination History</b> <b>Y N U</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Patient previously received rabies vaccine prior to this exposure If yes, date of previous vaccination: __/__/____	<b>Treatment</b> <b>Y N U</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Patient wound cleaned <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Patient started rabies <b>PEP</b> series If yes, name of facility initiating PEP series: _____  If yes, did patient <b>complete series?</b> : <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Please document known vaccination dates below: #1: __/__/____ #2: __/__/____ #3: __/__/____ #4: __/__/____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Patient received human rabies immune globulin ( <b>RIG</b> ) If yes, RIG date: __/__/____
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### ANIMAL INFORMATION

<b>Species Causing Exposure (mark all that apply):</b> <input type="checkbox"/> Bat <input type="checkbox"/> Fox <input type="checkbox"/> Raccoon <input type="checkbox"/> Cat or kitten <input type="checkbox"/> Goat <input type="checkbox"/> Rodent <input type="checkbox"/> Cow <input type="checkbox"/> Horse <input type="checkbox"/> Sheep <input type="checkbox"/> Coyote <input type="checkbox"/> Monkey <input type="checkbox"/> Skunk <input type="checkbox"/> Dog or puppy <input type="checkbox"/> Pig <input type="checkbox"/> OTHER (list): _____ <input type="checkbox"/> Ferret <input type="checkbox"/> Rabbit _____ Total number of animals involved in encounter: _____	<b>Ownership status of animal:</b> <input type="checkbox"/> Owned (pet, livestock, etc.) Owner Name: _____ Owner Address: _____ City/State/Zip: _____ Owner Phone: _____ <input type="checkbox"/> Non-owned (wild, stray, etc.) <input type="checkbox"/> Unknown
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### ADDITIONAL NOTES:

**INVESTIGATION SUMMARY**

Local Health Department (Jurisdiction): _____	Entered in WVEDSS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Investigation Start Date: __/__/____	<b>Case Classification:</b>
Earliest date reported to LHD: __/__/____	<input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspect
Earliest date reported to state: __/__/____	<input type="checkbox"/> Not a case <input type="checkbox"/> Unknown

Was owner contacted?  Yes  No Date Notified: \_\_/\_\_/\_\_\_\_ By:  Phone  Letter  Visit

**Rabies Vaccination Status of Animal:**

If pet or livestock, were rabies vaccinations up-to-date\*?  Yes (Date: \_\_/\_\_/\_\_\_\_)  No  Unknown  
 \*For cats, dogs and ferrets: 1<sup>st</sup> Dose @3mo, Booster @ 1yr; Booster every 1-3 yrs (depending on manufacturer)  
 Veterinarian: \_\_\_\_\_ Phone: \_\_\_\_\_

**EXPOSURE INFORMATION**

**Y N U**

Occupational exposure **If yes, indicate occupation:** \_\_\_\_\_

Exposure occurred outside the United States (If yes, please call DCDE immediately for consult)

Exposure occurred in a county with a history of animal rabies activity

Where did exposure occur? **County:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Country:** \_\_\_\_\_

**OBSERVATION TIMELINE**

<p><i>Instructions: enter exposure date in grey box. Count forward 10 days to determine observation period</i></p>	<p><b>Observation* Period</b></p> <table border="1" style="margin: auto;"> <tr> <td style="padding: 5px;"><b>+0 days</b> (Exposure date)</td> <td style="padding: 5px;"><b>+10 days</b> (Check Date)</td> </tr> <tr> <td style="padding: 5px;">Calendar dates: __/__/____</td> <td style="padding: 5px;">__/__/____</td> </tr> <tr> <td style="padding: 5px; text-align: center;">MM/DD/YYYY</td> <td style="padding: 5px; text-align: center;">MM/DD/YYYY</td> </tr> </table>	<b>+0 days</b> (Exposure date)	<b>+10 days</b> (Check Date)	Calendar dates: __/__/____	__/__/____	MM/DD/YYYY	MM/DD/YYYY	<p>*Period of observation for cats, dogs and ferrets is 10 days. For livestock, 14 days are recommended. Confinement of other species not appropriate.</p>
<b>+0 days</b> (Exposure date)	<b>+10 days</b> (Check Date)							
Calendar dates: __/__/____	__/__/____							
MM/DD/YYYY	MM/DD/YYYY							

**ANIMAL FOLLOW UP INFORMATION**

**Y N U**

Animal involved in exposure was able to be confined  
 if yes, indicate # days (from exposure to final check): \_\_\_ and final status: Healthy Died Lost Other: \_\_\_\_\_  
 If yes, indicate where animal confined:  Home  Animal Shelter  Veterinarian  Other: \_\_\_\_\_

Animal confinement not possible, but animal was able to be observed following the exposure  
 (if yes, indicate # days (from exposure to observation): \_\_\_ and final status: Healthy Died Lost Other: \_\_\_\_\_)

Other Animals Have Been Exposed (if yes, explain: \_\_\_\_\_)

If livestock involved, has Ag been contacted (304-558-2214)

**LABORATORY INFORMATION**

**Y N U**

Animal involved in exposure was submitted for rabies testing (If yes, date: \_\_/\_\_/\_\_\_\_ and Lab ID#: \_\_\_\_\_)

Rabies virus detected in exposing animal via direct fluorescent antibodies (DFA) (If yes, date: \_\_/\_\_/\_\_\_\_)

Patient notified of results (if applicable) (If yes, date: \_\_/\_\_/\_\_\_\_)

**PUBLIC HEALTH ISSUES**

**Y N U**

Human exposure to an animal that was lost-to-follow-up

Human exposure to an animal that was euthanized or killed and not available for testing

Other:

**PUBLIC HEALTH ACTIONS**

**Y N U**

Rabies education provided to patient

Patient referred to healthcare provider

Rabies PEP recommended to patient

Referred patient to national indigent rabies vaccine program

National B Virus Resource Center contacted to assist with exposure management (for exposures involving primates only)

Responsible pet ownership education provided to animal (i.e., spay/neuter, rabies vaccine, caution w/young children)

Outreach provided to employer to reduce employee risk (for occupationally-related exposures)

Patient lost to follow-up

Other:

**NOTES**

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