WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR PUBLIC HEALTH

# Rabies, Human

**Immediately notify WV Bureau for Public Health, Division of Infectious Disease Epidemiology 1-800-423-1271**

## PATIENT DEMOGRAPHICS

**Name** (last, first): _____
**Address** (mailing): _____
**Address** (physical): _____
**City/State/Zip**: _____
**Phone** (home): _____ **Phone** (work/cell) : _____
*Alternate contact:* ☐*Parent/Guardian* ☐*Spouse* ☐*Other*
*Name:*_____ *Phone:* _____

**Birth date**: ___/ ___/_____ **Age**: _____
**Sex**: ☐Male ☐Female ☐Unk
**Ethnicity**: ☐Not Hispanic or Latino ☐Hispanic or Latino ☐Unk
**Race**: (Mark all that apply) ☐White ☐Black/Afr. Amer. ☐Asian ☐Am. Ind/AK Native ☐Native HI/Other PI ☐ Unk

## INVESTIGATION SUMMARY

**Local Health Department** (Jurisdiction): _____
**Investigation Start Date**:_/_/ _____
**Earliest date reported to LHD**: ___/ ___/ _____
**Earliest date reported to DIDE**: ___/ ___/ _____

**Entered in WVEDSS?** ☐Yes ☐No ☐Unk
**Case Classification**:
☐ Confirmed ☐ Probable ☐ Suspect
☐ Not a case ☐ Unknown

## REPORT SOURCE/HEALTHCARE PROVIDER (HCP)

Report Source: ☐Laboratory ☐Hospital ☐HCP ☐Public Health Agency ☐Other
Reporter Name: _____ Reporter Phone: _____
Primary HCP Name:_____ Primary HCP Phone: _____

## CLINICAL

**Onset date**: ___/ ___/_____ **Diagnosis date**: ___/ ___/_____ **Recovery date**:_/_/ _____

### Clinical Findings

Y N U
☐ ☐ ☐ Fever (Highest measured temperature:_____ºF)
☐ ☐ ☐ Malaise
☐ ☐ ☐ Headache
☐ ☐ ☐ Nausea/vomiting
☐ ☐ ☐ Anxiety
☐ ☐ ☐ Muscle spasms
☐ ☐ ☐ Dysphagia
☐ ☐ ☐ Anorexia
☐ ☐ ☐ Ataxia
☐ ☐ ☐ Priapism
☐ ☐ ☐ Seizures
☐ ☐ ☐ Hyperactivity
☐ ☐ ☐ Hallucinations
☐ ☐ ☐ Insomnia

### Clinical Findings (continued)

Y N U
☐ ☐ ☐ Aerophobia
☐ ☐ ☐ Hydrophobia
☐ ☐ ☐ Localized weakness
☐ ☐ ☐ Localized pain/ Paresthesias
☐ ☐ ☐ Confusion or delirium
☐ ☐ ☐ Agitation or combativeness
☐ ☐ ☐ Autonomic instability
☐ ☐ ☐ Hypersalivation
☐ ☐ ☐ Encephalitis
☐ ☐ ☐ Ascending flaccid paralysis
☐ ☐ ☐ Coma

### Hospitalization

Y N U
☐ ☐ ☐ Patient hospitalized for this illness
If yes, hospital name: _____
Admit date: ___/ ___/_____ Discharge date:_/_/ _____

### Death

Y N U
☐ ☐ ☐ Patient died due to this illness If yes, date of death: / / _____

## VACCINATION HISTORY

Y N U
☐ ☐ ☐ Previously received rabies vaccine
If yes, date:_/_/_____

## LABORATORY *(Please submit copies of all labs associated with this illness to DIDE)*

Y N U
☐ ☐ ☐ Detection of Lyssavirus antigens in a clinical specimen (preferably the brain or the nerves surrounding hair follicles in the nape of the neck) by direct fluorescent antibody test
☐ ☐ ☐ Isolation (in cell culture or in a laboratory animal) of a Lyssavirus from saliva or central nervous system tissue
☐ ☐ ☐ Identification of Lyssavirus specific antibody (i.e. by indirect fluorescent antibody (IFA) test or complete rabies virus neutralization at 1:5 dilution) in the CSF
☐ ☐ ☐ Identification of Lyssavirus specific antibody (i.e. by indirect fluorescent antibody (IFA) test or complete rabies virus neutralization at 1:5 dilution) in the serum of an unvaccinated person
☐ ☐ ☐ Detection of Lyssavirus RNA (using reverse transcriptase–polymerase chain reaction [RT-PCR]) in saliva, CSF, or tissue

## INFECTION TIMELINE

*Instructions: Enter onset date in grey box. Count backward to determine probable exposure period*

| | Exposure period | | Onset date |
|---|---|---|---|
| *Days from onset* | ***-365+ (Max Incubation)*** | ***-3 (Min Incubation)*** | |
| ***Calendar dates:*** | ___/___/ ____ | ___/___/ ____ | ___/___/ ____ |

## EPIDEMIOLOGIC EXPOSURES (based on the above exposure period)

Y N U

☐ ☐ ☐ History of travel during exposure period (if yes, complete travel history below):

| Destination (City, Country) | Arrival Date | Departure Date | Reason for Travel |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

☐ ☐ ☐ Suspicious animal exposure(s)

**Most recent exposure**:

Date/location:_____

Species involved: ☐Dog ☐Cat ☐Raccoon ☐Skunk ☐Fox ☐Bat ☐Other:_____

Exposure type: ☐Bite ☐Scratch ☐Other:_____

**Previous exposure**:

Date/location:_____

Species involved: ☐Dog ☐Cat ☐Raccoon ☐Skunk ☐Fox ☐Bat ☐Other:_____

Exposure type: ☐Bite ☐Scratch ☐Other:_____

Where did exposure most likely occur? **County:** _____ **State:**_____ **Country:** _____

## PUBLIC HEALTH ISSUES

Y N U

☐ ☐ ☐ Case donated blood products, organs or tissue in the 30 days prior to symptom onset
Date:_/_/_____
Agency/location:_____
Type of donation:_____

☐ ☐ ☐ Potential human exposures

☐ ☐ ☐ Epi link to another confirmed case of same condition

☐ ☐ ☐ Epi link to a documented exposure

☐ ☐ ☐ Case is part of an outbreak

☐ ☐ ☐ Other:

## PUBLIC HEALTH ACTIONS

Y N U

☐ ☐ ☐ Notification of blood bank or hospital

☐ ☐ ☐ PEP recommended for human exposures (indicate #:_____)

☐ ☐ ☐ Disease education and prevention information provided to patient and/or family/guardian

☐ ☐ ☐ Facilitate laboratory testing of other symptomatic persons who have a shared exposure

☐ ☐ ☐ Patient is lost to follow up

☐ ☐ ☐ Other:

## WVEDSS

Y N U

☐ ☐ ☐ Entered into WVEDSS (**Entry date**: __ / __ /_____)

**Case Status:** ☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case ☐ Unknown

## NOTES