



LHJ Use ID \_\_\_\_\_  
 Reported to DOH Date \_\_\_/\_\_\_/\_\_\_  
 LHJ Classification  Confirmed  
 Probable  
 By:  Lab  Clinical  
 Epi Link: \_\_\_\_\_

Outbreak-related  
 LHJ Cluster# \_\_\_\_\_  
 LHJ Cluster Name: \_\_\_\_\_  
 DPHHS Outbreak # \_\_\_\_\_

# Rabies Post-Exposure Prophylaxis (PEP)

County: \_\_\_\_\_

## REPORT SOURCE

LHJ notification date \_\_\_/\_\_\_/\_\_\_  
 Reporter (check all that apply)  
 Lab  Hospital  HCP  
 Public health agency  Other  
 OK to talk to case?  Yes  No  Don't know

Investigation start date: \_\_\_/\_\_\_/\_\_\_

Reporter name \_\_\_\_\_  
 Reporter phone \_\_\_\_\_  
 Primary HCP name \_\_\_\_\_  
 Primary HCP phone \_\_\_\_\_

## PATIENT INFORMATION

Name (last, first) \_\_\_\_\_  
 Address \_\_\_\_\_  Homeless  
 City/State/Zip \_\_\_\_\_  
 Phone(s)/Email \_\_\_\_\_  
 Alt. contact  Parent/guardian  Spouse  Other Name: \_\_\_\_\_  
 Zip code (school or occupation): \_\_\_\_\_ Phone: \_\_\_\_\_  
 Occupation/grade \_\_\_\_\_  
 Employer/worksite \_\_\_\_\_ School/child care name \_\_\_\_\_

Birth date \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_  
 Gender  F  M  Other  Unk  
 Ethnicity  Hispanic or Latino  
 Not Hispanic or Latino  
 Race (check all that apply)  
 Amer Ind/AK Native  Asian  
 Native HI/other PI  Black/Afr Amer  
 White  Other

## CLINICAL INFORMATION

**Hospitalization**  
 Y N DK NA  
    Hospitalized for this illness  
 Hospital name \_\_\_\_\_  
 Admit date \_\_\_/\_\_\_/\_\_\_ Discharge date \_\_\_/\_\_\_/\_\_\_  
 Y N DK NA  
    Died from illness Death date \_\_\_/\_\_\_/\_\_\_  
    Autopsy Place of death \_\_\_\_\_

**Laboratory**  
 P = Positive O = Other  
 N = Negative NT = Not Tested  
 I = Indeterminate  
 Collection date \_\_\_/\_\_\_/\_\_\_  
 P N I O NT  
     Animal rabies testing  
 Date animal submitted for testing: \_\_\_/\_\_\_/\_\_\_  
 Results expected date: \_\_\_/\_\_\_/\_\_\_  
 Lab submitted to: \_\_\_\_\_

**Vaccination**  
 Y N DK NA  
    Patient ever received rabies containing vaccine  
 Number of doses prior to exposure: \_\_\_\_\_  
 Dose 1 Date received: \_\_\_/\_\_\_/\_\_\_  
 Dose 2 Date received: \_\_\_/\_\_\_/\_\_\_  
 Dose 3 Date received: \_\_\_/\_\_\_/\_\_\_  
 Dose 4 Date received: \_\_\_/\_\_\_/\_\_\_  
 Dose 5 Date received: \_\_\_/\_\_\_/\_\_\_  
    Patient completed rabies vaccine series in past (at least 3 doses)  
    Tetanus vaccine in the last 5 years  
 Date of last tetanus dose: \_\_\_/\_\_\_/\_\_\_

**NOTES**

**EXPOSURE**

Y N DK NA

- Travel out of the state, out of the country, or outside of usual routine  
 Out of:  County  State  Country  
 Destinations/Dates: \_\_\_\_\_  
 \_\_\_\_\_

Circumstances of animal exposure: \_\_\_\_\_  
 \_\_\_\_\_Wound cleaned:  Y  N  DK  NAAnimal exposure provoked  Y  N  DK  NAOthers exposed to animal  Y  N  DK  NA

Y N DK NA

- Animal exposure  
 Type of animal exposure:  
 Bite  Saliva  Scratch  
 Bat in house  Bat in sleeping area  
 Other: \_\_\_\_\_  Unk  
 Type of animal:  
 Bat  Cat  Dog  Ferret  Raccoon  
 Other: \_\_\_\_\_  Unk  
 Animal status:  
 Domestic  Stray  Wild  
 Other: \_\_\_\_\_  Unk  
 Animal description: \_\_\_\_\_  
 Breed: \_\_\_\_\_  
 Animal name: \_\_\_\_\_

Y N DK NA

- Animal vaccination history known  
 Animal rabies vaccination status:  
 Unvaccinated or vaccine not current  
 Vaccinated  Unk  
 Date of (animal) last rabies vaccine: \_\_\_/\_\_\_/\_\_\_  
 Total # (animal) rabies doses: \_\_\_\_\_

Y N DK NA

- Animal contact/control information known  
 Animal owner or location (e.g. park) name: \_\_\_\_\_  
 \_\_\_\_\_  
 Owner or location address: \_\_\_\_\_  
 \_\_\_\_\_  
 Owner or location phone number: \_\_\_\_\_  
 Veterinary clinic name: \_\_\_\_\_  
 Clinic address: \_\_\_\_\_  
 Clinic phone: \_\_\_\_\_  
 Veterinarian name: \_\_\_\_\_  
 Animal control contact name: \_\_\_\_\_  
 Animal control contact phone: \_\_\_\_\_

Y N DK NA

- Injury or exposure circumstances known  
 Date of exposure: \_\_\_/\_\_\_/\_\_\_  
 Exposure location: \_\_\_\_\_  
 Anatomic site of injury or wound (e.g., head, arm): \_\_\_\_\_

Where did exposure probably occur?  In MT (County: \_\_\_\_\_)  US but not MT  Not in US  Unk

Exposure details: \_\_\_\_\_

 No risk factors or exposures could be identified Patient could not be interviewed**PATIENT PROPHYLAXIS / TREATMENT**

Y N DK NA

- Human RIG given  
 Date: \_\_\_/\_\_\_/\_\_\_  
 Prescribing health care provider: \_\_\_\_\_  
 \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 RIG refused (complete refusal form)  
   Rabies vaccine given  
 Date of initial vaccination: \_\_\_/\_\_\_/\_\_\_  
 Vaccine name: \_\_\_\_\_  
 Prescribing health care provider: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Vaccination refused  
   Did case receive full series of PEP?  
 If not, reason:  
 Animal tested negative for rabies  
 Other, specify: \_\_\_\_\_

**Recommendations**

Y N DK NA

- PEP recommended  
 Weight: \_\_\_\_\_

**Determined by:**

LHJ \_\_\_\_\_  
 DOH \_\_\_\_\_  
 HCP \_\_\_\_\_

**Referral for follow-up:**

LHJ \_\_\_\_\_  
 DOH \_\_\_\_\_  
 HCP \_\_\_\_\_

**PUBLIC HEALTH ISSUES**

Y N DK NA

- Public health actions

**PUBLIC HEALTH ACTIONS**

- Animal disposition:  Sent for testing  Under observation  
 Healthy after 10 day observation  
 Lost to follow-up  Other: \_\_\_\_\_  
 Quarantine site contact name: \_\_\_\_\_  
 Quarantine site address: \_\_\_\_\_  
 Quarantine site phone: \_\_\_\_\_

Investigator \_\_\_\_\_ Phone/email: \_\_\_\_\_

Investigation complete date \_\_\_/\_\_\_/\_\_\_

Local health jurisdiction \_\_\_\_\_

Record complete date \_\_\_/\_\_\_/\_\_\_