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: ______

Public reporting burden of this collection of information is estimated to average 17 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB Control Number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Request Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30329; ATTN: PRA (0920-0728).

Possible Human Rabies—Patient Information

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: ________

Symptom			Symptom			Symptom		
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:

Test				
HSV CSF PCR	☐ NEG	☐ POS	☐ Not done	☐ Pending
Varicella CSF PCR	☐ NEG	☐ POS	☐ Not done	☐ Pending
CMV CSF PCR	☐ NEG	☐ POS	☐ Not done	☐ Pending
Enterovirus CSF PCR	☐ NEG	☐ POS	☐ Not done	☐ Pending
CrAg CSF	☐ 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):

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

Other: ________