State of California—Health and Human Services Agency

Local ID Number: _____

California Department of Public Health
Center for Infectious Diseases
Division of Communicable Disease Control
Infectious Diseases Branch
Surveillance and Statistics Section
MS 7306, P.O. Box 997377
Sacramento, CA 95899-7377

HUMAN RABIES CASE REPORT

PATIENT INFORMATION

Last Name	*First Name*	*Middle Name*	*Suffix*

Social Security Number (9 digits)	*DOB (mm/dd/yyyy)*	*Age*	☐ Years ☐ Months ☐ Days

Address Number & Street – Residence	*Apartment / Unit Number*

City / Town	*State*	*Zip Code*

Census Tract	*County of Residence*	*Country of Residence*

Country of Birth	*If not U.S. Born - Date of Arrival in U.S. (mm/dd/yyyy)*

Home Telephone	*Cellular Phone / Pager*	*Work / School Telephone*

E-mail Address	*Other Electronic Contact Information*

Work / School Location	*Work / School Contact*

Gender
☐ Female ☐ Trans female / transwoman ☐ Genderqueer or non-binary ☐ Unknown
☐ Male ☐ Trans male/ transman ☐ Identity not listed ☐ Declined to answer

Pregnant? ☐ Yes ☐ No ☐ Unknown	*If Yes, Est. Delivery Date (mm/dd/yyyy)*

Medical Record Number	*Patient's Parent/Guardian Name*

Occupation Setting (see list on page 7)	*Other Describe/Specify*

Occupation (see list on page 7)	*Other Describe/Specify*

Primary Language
☐ English
☐ Spanish
☐ Other: _____

Ethnicity (check one)
☐ Hispanic/Latino
☐ Non-Hispanic/Non-Latino
☐ Unknown

Race(s)
(check all that apply, race descriptions on page 6)

The response to this item should be based on the patient's self-identity or self-reporting. Therefore, patients should be offered the option of selecting more than one racial designation.

☐ American Indian or Alaska Native

☐ Asian *(check all that apply, see list on page 6)*
- ☐ Asian Indian
- ☐ Bangladeshi
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Hmong
- ☐ Indonesian
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Malaysian
- ☐ Pakistani
- ☐ Sri Lankan
- ☐ Taiwanese
- ☐ Thai
- ☐ Vietnamese
- ☐ Other: _____

☐ Black or African-American

☐ Native Hawaiian or Other Pacific Islander *(check all that apply, see list on page 6)*
- ☐ Native Hawaiian
- ☐ Fijian
- ☐ Guamanian
- ☐ Samoan
- ☐ Tongan
- ☐ Other: _____

☐ White

☐ Other: _____

☐ Unknown

ADDITIONAL PATIENT DEMOGRAPHICS

Sex Assigned at Birth
☐ Female ☐ Unknown
☐ Male ☐ Declined to answer

Sexual Orientation
☐ Heterosexual or straight ☐ Questioning, unsure, or patient doesn't know ☐ Declined to answer
☐ Gay, lesbian, or same-gender loving ☐ Orientation not listed ☐ Unknown
☐ Bisexual

CLINICAL INFORMATION

Physician Name - Last Name	*First Name*	*Telephone Number*

First three letters of patient's last name: | | | |

SIGNS AND SYMPTOMS

Symptomatic? ☐ Yes ☐ No ☐ Unknown	Onset Date (mm/dd/yyyy)	Date First Sought Medical Care (mm/dd/yyyy)

Signs and Symptoms	Yes	No	Unk	Signs and Symptoms	Yes	No	Unk
Fever *If Yes, highest temperature:* _____ *specify °F/°C*				Ataxia			
				Priapism			
Encephalitis				Seizures			
Myelitis				Hydrophobia			
Ascending flaccid paralysis				Localized weakness			
Aerophobia				Localized pain or paraesthesia			
Malaise				Confusion or delirium			
Headache				Agitation or combativeness			
Nausea or vomiting				Autonomic instability			
Anxiety				Hyperactivity			
Muscle spasm				Hallucinations			
Dysphagia				Insomnia			
Anorexia				Hypersalivation			

Other signs / symptoms (specify)

PAST MEDICAL HISTORY - RABIES VACCINATION

If the patient has a history of rabies vaccination(s), please specify below.

Vaccine Name 1	*Date of Vaccination (mm/dd/yyyy)*
Vaccine Name 2	*Date of Vaccination (mm/dd/yyyy)*
Vaccine Name 3	*Date of Vaccination (mm/dd/yyyy)*

PAST MEDICAL HISTORY - OTHER

Other condition? ☐ Yes ☐ No ☐ Unknown	*If Yes, specify*

HOSPITALIZATION

Did the patient visit the emergency room for illness? ☐ Yes ☐ No ☐ Unknown

Was the patient hospitalized? ☐ Yes ☐ No ☐ Unknown	*If Yes, how many total hospital nights?*	*During any part of the hospitalization, did the patient stay in an intensive care unit (ICU) or a critical care unit (CCU)?* ☐ Yes ☐ No ☐ Unknown

If there were any ER visits or hospital stays related to this illness, specify details in the Hospitalization – Details section on page 3.

First three letters of patient's last name: | | | |

HOSPITALIZATION – DETAILS

Hospital Name 1	Street Address			Admit Date (mm/dd/yyyy)	
	City			Discharge / Transfer Date (mm/dd/yyyy)	
	State	Zip Code	Telephone Number	Medical Record Number	Discharge Diagnosis
Hospital Name 2	Street Address			Admit Date (mm/dd/yyyy)	
	City			Discharge / Transfer Date (mm/dd/yyyy)	
	State	Zip Code	Telephone Number	Medical Record Number	Discharge Diagnosis

COMA

Was the patient in a coma? ☐ Yes ☐ No ☐ Unknown	If Yes, coma onset date (mm/dd/yyyy)	Additional Information

TREATMENT / MANAGEMENT

Local treatment of wound? ☐ Yes ☐ No ☐ Unknown	If Yes, date of treatment (mm/dd/yyyy)	Additional Information
Postexposure prophylaxis? ☐ Yes ☐ No ☐ Unknown	If Yes, specify type of products	If Yes, specify the treatments below.

TREATMENT / MANAGEMENT - DETAILS

Rabies immune globulin given? ☐ Yes ☐ No ☐ Unknown	Name of Rabies Immune Globulin ☐ HyperRAB ☐ Imogam-Rabies HT ☐ Other: _____ ☐ HyperRAB S/D ☐ KEDRAB	Date of Administration (mm/dd/yyyy)
	Total dose (IUs) of Immune Globulin Administered	Anatomic Location(s) Where Immune Globulin Administered
Rabies vaccine given? ☐ Yes ☐ No ☐ Unknown	Name of Rabies Vaccine ☐ RabAvert ☐ Imovax ☐ Other (specify): _____	
	First Dose (mm/dd/yyyy)	Last Dose (mm/dd/yyyy) / Number of Doses

OUTCOME

Outcome? ☐ Survived ☐ Died ☐ Unknown	If Survived, Survived as of (mm/dd/yyyy)	Date of Death (mm/dd/yyyy)

LABORATORY INFORMATION

LABORATORY RESULTS SUMMARY

Specimen Type 1 ☐ Serum ☐ CSF ☐ Nuchal biopsy ☐ Brain ☐ Saliva ☐ Corneal Impression ☐ Other:_____	Type of Test ☐ IFA ☐ RFFIT ☐ DFA ☐ PCR ☐ Other:_____		Collection Date (mm/dd/yyyy)
	Results	If Serum, specify titer	Interpretation ☐ Positive ☐ Negative ☐ Equivocal
	Laboratory Name		Telephone Number
Specimen Type 2 ☐ Serum ☐ CSF ☐ Nuchal biopsy ☐ Brain ☐ Saliva ☐ Corneal Impression ☐ Other:_____	Type of Test ☐ IFA ☐ RFFIT ☐ DFA ☐ PCR ☐ Other:_____		Collection Date (mm/dd/yyyy)
	Results	If Serum, specify titer	Interpretation ☐ Positive ☐ Negative ☐ Equivocal
	Laboratory Name		Telephone Number

First three letters of patient's last name: | | | |

EPIDEMIOLOGIC INFORMATION

INCUBATION PERIOD: 12 MONTHS PRIOR TO ILLNESS ONSET

ANIMAL EXPOSURES

Did the patient come into contact with animal(s) during the incubation period?
☐ Yes ☐ No ☐ Unknown

If Yes, specify animal exposures below.

ANIMAL EXPOSURES - DETAILS

Animal 1
☐ Bat ☐ Fox
☐ Skunk ☐ Dog
☐ Raccoon ☐ Cat
☐ Other:_____

Type of Exposure
☐ Bite ☐ Unknown
☐ Nonbite (scratch) ☐ Other: _____
☐ Nonbite (contact)

If bitten, specify Anatomic Site and County where bite occurred
Anatomic Site of Bite | *County*

Exposure Start Date (mm/dd/yyyy) | *Exposure End Date (mm/dd/yyyy)* | *Exposure Circumstances*

Animal 2
☐ Bat ☐ Fox
☐ Skunk ☐ Dog
☐ Raccoon ☐ Cat
☐ Other:_____

Type of Exposure
☐ Bite ☐ Unknown
☐ Nonbite (scratch) ☐ Other: _____
☐ Nonbite (contact)

If bitten, specify Anatomic Site and County where bite occurred
Anatomic Site of Bite | *County*

Exposure Start Date (mm/dd/yyyy) | *Exposure End Date (mm/dd/yyyy)* | *Exposure Circumstances*

OCCUPATIONAL / RECREATIONAL EXPOSURES

Rabies laboratory?
☐ Yes ☐ No ☐ Unknown

Laboratory Name

Exposure Activity

Other occupational/recreational exposures?
☐ Yes ☐ No ☐ Unknown

If Yes, specify

TRAVEL HISTORY

*Did the patient travel **outside county of residence** during the **incubation period**?*
☐ Yes ☐ No ☐ Unknown

If Yes, specify all locations and dates below.

TRAVEL HISTORY – DETAILS

Travel Type	State	Country	Other location details (city, resort, etc.)	Date Travel Started *(mm/dd/yyyy)*	Date Travel Ended *(mm/dd/yyyy)*
☐ Domestic ☐ Unknown ☐ International					
☐ Domestic ☐ Unknown ☐ International					
☐ Domestic ☐ Unknown ☐ International					

ILL CONTACTS

Any contacts with similar illness (including household contacts)?
☐ Yes ☐ No ☐ Unknown

If Yes, specify details below.

ILL CONTACTS - DETAILS

Name 1

Age | *Gender* | *Telephone Number* | *Type of Contact / Relationship* | *Date of Contact (mm/dd/yyyy)*

Street Address | *Exposure Event* | *Illness Onset Date (mm/dd/yyyy)*

City | *State* | *Zip Code* | *Date First Reported to Public Health (mm/dd/yyyy)*

Name 2

Age | *Gender* | *Telephone Number* | *Type of Contact / Relationship* | *Date of Contact (mm/dd/yyyy)*

Street Address | *Exposure Event* | *Illness Onset Date (mm/dd/yyyy)*

City | *State* | *Zip Code* | *Date First Reported to Public Health (mm/dd/yyyy)*

First three letters of patient's last name: | | | |

NOTES / REMARKS

REPORTING AGENCY

Investigator Name	*Local Health Jurisdiction*	*Telephone Number*	*Date (mm/dd/yyyy)*

First Reported By

☐ Clinician ☐ Laboratory ☐ Other (specify):_____

EPIDEMIOLOGICAL LINKAGE

Epi-linked to known case?	*Contact Name / Case Number*
☐ Yes ☐ No ☐ Unknown	

DISEASE CASE CLASSIFICATION

Case Classification (see case definition below)

☐ Confirmed ☐ Not a case

STATE USE ONLY

State Case Classification

☐ Confirmed ☐ Not a case ☐ Need additional information

CASE DEFINITION

HUMAN RABIES (2011)

CLINICAL DESCRIPTION

Rabies is an acute encephalomyelitis that almost always progresses to coma or death within 10 days after the first symptom.

LABORATORY CRITERIA FOR DIAGNOSIS

- 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, or
- Isolation (in cell culture or in a laboratory animal) of a Lyssavirus from saliva or central nervous system tissue, or
- 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, or
- 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, or
- Detection of Lyssavirus viral RNA (using reverse transcriptase-polymerase chain reaction [RT-PCR]) in saliva, CSF, or tissue

CASE CLASSIFICATION

Confirmed: a clinically compatible case that is laboratory confirmed by testing at a state or federal public heatlh laboratory.

COMMENT

Laboratory confirmation by all of the above methods is strongly recommended.

First three letters of patient's last name: | | | |

RACE DESCRIPTIONS

Race	Description
American Indian or Alaska Native	Patient has origins in **any** of the original peoples of North and South America (including Central America).
Asian	Patient has origins in **any** of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent (e.g., including Bangladesh, Cambodia, China, India, Indonesia, Japan, Korea, Malaysia, Nepal, Pakistan, the Philippine Islands, Thailand, and Vietnam).
Black or African American	Patient has origins in **any** of the black racial groups of Africa.
Native Hawaiian or Other Pacific Islander	Patient has origins in **any** of the original peoples of Hawaii, Guam, American Samoa, or other Pacific Islands.
White	Patient has origins in **any** of the original peoples of Europe, the Middle East, or North Africa.

ASIAN GROUPS

- Bangladeshi
- Bhutanese
- Burmese
- Cambodian
- Chinese
- Filipino
- Hmong
- Indian
- Indonesian
- Iwo Jiman
- Japanese
- Korean
- Laotian
- Madagascar
- Malaysian
- Maldivian
- Nepalese
- Okinawan
- Pakistani
- Singaporean
- Sri Lankan
- Taiwanese
- Thai
- Vietnamese

NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER GROUPS

- Carolinian
- Chamorro
- Chuukese
- Fijian
- Guamanian
- Kiribati
- Kosraean
- Mariana Islander
- Marshallese
- Melanesian
- Micronesian
- Native Hawaiian
- New Hebrides
- Palauan
- Papua New Guinean
- Pohnpeian
- Polynesian
- Saipanese
- Samoan
- Solomon Islander
- Tahitian
- Tokelauan
- Tongan
- Yapese

First three letters of patient's last name: | | | |

OCCUPATION SETTING

- Childcare/Preschool
- Correctional Facility
- Drug Treatment Center
- Food Service
- Health Care - Acute Care Facility
- Health Care - Long Term Care Facility
- Health Care - Other
- Homeless Shelter
- Laboratory
- Military Facility
- Other Residential Facility
- Place of Worship
- School
- Other

OCCUPATION

- Agriculture - farmworker or laborer (crop, nursery, or greenhouse)
- Agriculture - field worker
- Agriculture - migratory/seasonal worker
- Agriculture - other/unknown
- Animal - animal control worker
- Animal - farm worker or laborer (farm or ranch animals)
- Animal - veterinarian or other animal health practitioner
- Animal - other/unknown
- Clerical, office, or sales worker
- Correctional facility - employee
- Correctional facility - inmate
- Craftsman, foreman, or operative
- Daycare or child care attendee
- Daycare or child care worker
- Dentist or other dental health worker
- Drug dealer
- Fire fighting or prevention worker
- Flight attendant
- Food service - cook or food preparation worker
- Food service - host or hostess
- Food service - waiter or waitress
- Food service - other/unknown
- Homemaker
- Laboratory technologist or technician
- Laborer - private household or unskilled worker
- Manager, official, or proprietor
- Manicurist or pedicurist
- Medical - emergency medical technician or paramedic
- Medical - health care worker
- Medical - medical assistant
- Medical - pharmacist
- Medical - physician assistant or nurse practitioner
- Medical - physician or surgeon
- Medical - registered nurse
- Medical - other/unknown
- Military - officer
- Military - recruit or trainee
- Protective service - police officer
- Protective service - other
- Professional, technical, or related profession
- Retired
- Sex worker
- Student - preschool or kindergarten
- Student - elementary or middle school
- Student - high (secondary) school
- Student - college or university
- Student - other/unknown
- Teacher/employee - preschool or kindergarten
- Teacher/employee - elementary or middle school
- Teacher/employee - high (secondary) school
- Teacher/instructor/employee - college or university
- Teacher/instructor/employee - other/unknown
- Unemployed - seeking employment
- Unemployed - not seeking employment
- Unemployed - other/unknown
- Other
- Refused
- Unknown