



Possible Human Rabies - Patient Information Form



Please print the following form and fill it out as completely as possible. A copy of this form must accompany diagnostic specimens. Send completed form with samples

to: Rabies Laboratory
DASH, Bldg 18, Rm SSB218
Centers for Disease Control and Prevention
1600 Clifton Rd, NE
Atlanta, GA 30333

and/or
Fax: Attn: Rabies Duty Officer
404-639-1564

Physician Contact Information

Physician's Name

Physician's Contact Number

Hospital

City State

Send Report to

Please indicate person to receive official report of results

Fax Number

Email Address

Patient Information

Patient Name / Identifier

Gender Date of Birth

Occupation

First Symptoms

Date of Illness Onset

Outpatient Visit Date

Outpatient Diagnosis

Hospitalized Yes No

Date Hospitalized

Admitting Diagnosis

Is/was the patient in a coma Yes No

Date of coma onset

Has the patient expired Yes No

Date of Death

Current differential diagnosis

Samples Submitted

All four samples are required to provide an antemortem rule out of rabies.

Please provide date(s) of collection for each sample.

	Date 1	Date 2	Date 3	Date 4
<input type="checkbox"/> Nuchal biopsy	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Saliva	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Serum	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> CSF	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Symptoms

Which of the following symptoms have been present? Mark all that apply.

Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Aerophobia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Malaise	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Hydrophobia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Headache	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Localized Weakness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Nausea / Vomiting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Localized Pain / Parasthesia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Anxiety	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Confusion or delirium	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Muscle Spasm	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Agitation / Combativeness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Dysphagia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Autonomic instability	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Anorexia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Hyperactivity	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Ataxia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Hallucinations	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Priapism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Insomnia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Hypersalivation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

Laboratory Findings

Peripheral WBC (with diff)

On Admission x10³/ul

Neutrophils %

lymphocytes %

monocytes %

bands %

Highest x10³/ul

Neutrophils %

lymphocytes %

monocytes %

bands %

Chemistry

Glucose, serum mg/dl

Total Protein, serum g/dl

CPK, serum - total U/l

Isoenzymes - MM %

MB %

BB %

CSF Findings

RBC /ul

WBC /ul

Neutrophils %

Lymphocytes %

Monocytes %

bands %

Glucose mg/dl

Protein mg/dl

Culture results

Additional abnormal
Laboratory Values

Additional Pertinent
Clinical Information /
Diagnostic results

Additional Information

Patient Residence and Travel

Location of residence at time of onset Urban Suburban Rural

City State

Has the Patient traveled to any foreign country in the past 6 months?

Country 1 Number of days

Country 2 Number of days

Animal Exposure

Any suspicious animal exposures? Yes No

*Most Recent exposure

City <input type="text"/>	State <input type="text"/>
Date of exposure <input type="text"/>	
Species involved in most recent exposure	Type of exposure
<input type="checkbox"/> Dog	<input type="checkbox"/> Bite
<input type="checkbox"/> Cat	<input type="checkbox"/> Nonbite (scratch)
<input type="checkbox"/> Raccoon	<input type="checkbox"/> Nonbite (contact only)
<input type="checkbox"/> Skunk	<input type="checkbox"/> No known exposure
<input type="checkbox"/> Fox	<input type="checkbox"/> Unknown
<input type="checkbox"/> Bat	
<input type="checkbox"/> Other specify <input type="text"/>	

*Previous exposure

City <input type="text"/>	State <input type="text"/>
Date of exposure <input type="text"/>	
Species involved in previous exposure	Type of exposure
<input type="checkbox"/> Dog	<input type="checkbox"/> Bite
<input type="checkbox"/> Cat	<input type="checkbox"/> Nonbite (scratch)
<input type="checkbox"/> Raccoon	<input type="checkbox"/> Nonbite (contact only)
<input type="checkbox"/> Skunk	<input type="checkbox"/> No known exposure
<input type="checkbox"/> Fox	<input type="checkbox"/> Unknown
<input type="checkbox"/> Bat	
<input type="checkbox"/> Other specify <input type="text"/>	