State of California—Health and Human Services Agency

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

Local ID Number _____

(*Please use the same ID Number on the preliminary and final reports to allow linkage to the same case.)*

Report Status (check one)

☐Preliminary ☐Final

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*

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*

Gender
☐Male ☐Female ☐Other: _____

E-mail Address	*Other Electronic Contact Information*

Work/School Location	*Work/School Contact*

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

Medical Record Number	*If not U.S. Born - Date of Arrival in U.S. (mm/dd/yyyy)*

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
☐Unk

*Race**
(check all that apply, race descriptions on page 7)
☐African-American/Black
☐American Indian or Alaska Native
☐Asian *(check all that apply)*
- ☐Asian Indian ☐Japanese
- ☐Cambodian ☐Korean
- ☐Chinese ☐Laotian
- ☐Filipino ☐Thai
- ☐Hmong ☐Vietnamese
- ☐Other:_____

☐Pacific Islander *(check all that apply)*
- ☐Native Hawaiian ☐Samoan
- ☐Guamanian
- ☐Other:_____

☐White
☐Other:_____
☐Unk

*Comment: self-identity or self-reporting
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.

CLINICAL INFORMATION

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

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

SIGNS AND SYMPTOMS

Symptomatic? ☐Yes ☐No ☐Unk	*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 ☐Unk	*If Yes, specify*

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

HOSPITALIZATION

Did patient visit emergency room for illness? ☐Yes ☐No ☐Unk	Was patient hospitalized? ☐Yes ☐No ☐Unk	If Yes, how many total hospital nights?
If there were any ER or hospital stays related to this illness, specify details below.		

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 ☐Unk	If Yes, coma onset date (mm/dd/yyyy)	Additional Information

TREATMENT / MANAGEMENT

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

TREATMENT / MANAGEMENT - DETAILS

Rabies immune globulin given? ☐Yes ☐No ☐Unk	Number of Doses		Date Administered (mm/dd/yyyy)
	Manufacturer		Lot Number
Rabies vaccine given? ☐Yes ☐No ☐Unk	Number of Doses	First Dose (mm/dd/yyyy)	Last Dose (mm/dd/yyyy)
	Manufacturer		Lot Number

OUTCOME

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

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

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

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 ☐Unk

If Yes, specify animal exposures below.

ANIMAL EXPOSURES - DETAILS

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

Type of Exposure
☐Bite ☐No known exposure
☐Nonbite (scratch) ☐Unk
☐Nonbite (contact) ☐Other: _____

If bitten, specify Anatomic Site and County where bite occurred

Anatomic Site of Bite

County

Exposure Start Date (mm/dd/yyyy)

Exposure Start Date (mm/dd/yyyy)

Exposure Circumstances

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

Type of Exposure
☐Bite ☐No known exposure
☐Nonbite (scratch) ☐Unk
☐Nonbite (contact) ☐Other: _____

If bitten, specify Anatomic Site and County where bite occurred

Anatomic Site of Bite

County

Exposure Start Date (mm/dd/yyyy)

Exposure Start Date (mm/dd/yyyy)

Exposure Circumstances

OCCUPATIONAL / RECREATIONAL EXPOSURES

Rabies laboratory?
☐Yes ☐No ☐Unk

Laboratory Name

Exposure Activity

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

If Yes, specify

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

TRAVEL HISTORY

Did patient travel outside of county of residence during the incubation period? ☐Yes ☐No ☐Unk	*If Yes, specify all locations and dates below.*

TRAVEL HISTORY - DETAILS

Location (city, county, state, country)	Date Travel Started (mm/dd/yyyy)	Date Travel Ended (mm/dd/yyyy)

ILL CONTACTS

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

NOTES / REMARKS

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

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? ☐Yes ☐No ☐Unk	*Contact Name / Case Number*		
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.

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.

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

- Adult film actor/actress
- 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 - server
- 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 - nurse
- Medical - other/unknown
- Military
- Police officer
- Professional, technical, or related profession
- Retired
- Sex worker
- Stay at home parent/guardian
- Student - preschool or kindergarten
- Student - elementary or middle school
- Student - high school
- Student - college or university
- Student - other/unknown
- Teacher/employee - preschool or kindergarten
- Teacher/employee - elementary or middle school
- Teacher/employee - high school
- Teacher/instructor/employee - college or university
- Teacher/instructor/employee - other/unknown
- Unemployed - seeking employment
- Unemployed - not seeking employment
- Unemployed - other/unknown
- Volunteer
- Other
- Refused
- Unknown