

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	Primary Language	
Social Security Number (9 digits)		DOB (mm/dd/yyyy)	Age	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	
Address Number & Street - Residence		Apartment/Unit Number		Ethnicity (check one)	
City/Town		State	Zip Code	<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Unk	
Census Tract	County of Residence	Country of Residence		Race* (check all that apply, race descriptions on page 7)	
Country of Birth		If not U.S. Born - Date of Arrival in U.S. (mm/dd/yyyy)		<input type="checkbox"/> African-American/Black <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian (check all that apply)	
Home Telephone	Cellular Phone/Pager	Work/School Telephone		<input type="checkbox"/> Asian Indian <input type="checkbox"/> Japanese <input type="checkbox"/> Cambodian <input type="checkbox"/> Korean <input type="checkbox"/> Chinese <input type="checkbox"/> Laotian <input type="checkbox"/> Filipino <input type="checkbox"/> Thai <input type="checkbox"/> Hmong <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other: _____	
E-mail Address		Other Electronic Contact Information		<input type="checkbox"/> Pacific Islander (check all that apply) <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Guamanian <input type="checkbox"/> Other: _____	
Work/School Location		Work/School Contact		<input type="checkbox"/> White <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unk	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____					
Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		If Yes, Est. Delivery Date (mm/dd/yyyy)		<input type="checkbox"/> White <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unk	
Medical Record Number		Patient's Parent/Guardian Name		*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.	
Occupation Setting (see list on page 7)		Other Describe/Specify			
Occupation (see list on page 7)		Other Describe/Specify			
CLINICAL INFORMATION					
Physician Name - Last Name			First Name		Telephone Number

First three letters of patient's last name:

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SIGNS AND SYMPTOMS

Symptomatic? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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	<i>If Yes, highest temperature:</i> _____ <i>specify °F/°C</i>				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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<i>If Yes, specify</i>
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First three letters of
patient's last name:

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HOSPITALIZATION					
Did patient visit emergency room for illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Was patient hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		If Yes, coma onset date (mm/dd/yyyy)		Additional Information	
TREATMENT / MANAGEMENT					
Local treatment of wound? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		If Yes, date of treatment (mm/dd/yyyy)		Additional Information	
Postexposure prophylaxis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		If Yes, specify type of products		If Yes, specify the treatments below.	
TREATMENT / MANAGEMENT - DETAILS					
Rabies immune globulin given? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Number of Doses			Date Administered (mm/dd/yyyy)	
	Manufacturer			Lot Number	
Rabies vaccine given? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Number of Doses		First Dose (mm/dd/yyyy)	Last Dose (mm/dd/yyyy)	
	Manufacturer			Lot Number	
OUTCOME					
Outcome? <input type="checkbox"/> Survived <input type="checkbox"/> Died <input type="checkbox"/> Unk		If Survived, Survived as of (mm/dd/yyyy)		Date of Death (mm/dd/yyyy)	

First three letters of patient's last name:

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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:

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REPORTING AGENCY			
<i>Investigator Name</i>	<i>Local Health Jurisdiction</i>	<i>Telephone Number</i>	<i>Date (mm/dd/yyyy)</i>
<i>First Reported By</i> <input type="checkbox"/> Clinician <input type="checkbox"/> Laboratory <input type="checkbox"/> Other (specify): _____			
EPIDEMIOLOGICAL LINKAGE			
<i>Epi-linked to known case?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<i>Contact Name / Case Number</i>		
DISEASE CASE CLASSIFICATION			
<i>Case Classification (see case definition below)</i> <input type="checkbox"/> Confirmed <input type="checkbox"/> Not a case			
STATE USE ONLY			
<i>State Case Classification</i> <input type="checkbox"/> Confirmed <input type="checkbox"/> Not a case <input type="checkbox"/> Need additional information			
CASE DEFINITION			
<u>HUMAN RABIES (2011)</u>			
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			
<ul style="list-style-type: none"> • 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 health 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	
<ul style="list-style-type: none"> • Childcare/Preschool • Correctional Facility • Drug Treatment Center • Food Service • Health Care - Acute Care Facility • Health Care - Long Term Care Facility • Health Care - Other 	<ul style="list-style-type: none"> • Homeless Shelter • Laboratory • Military Facility • Other Residential Facility • Place of Worship • School • Other
OCCUPATION	
<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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