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| **SUSPECTED HUMAN RABIES CASE HISTORY FORM** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Filled in by: | | | | | | | | | | |  | | | | | | | | | | | | | | | Contact number: | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| Date: | | | | | | | | | | | \_\_/\_\_/\_\_\_\_ | | | | | | | | | | | | | | | Information collected from: | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
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| PATIENT INFORMATION | | | | | | | | | | | | | | | | | | | | | | CLINICAL FEATURES*Tick appropriate box (yes; no, UNK: unknown)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name: | | | | | | | | |  | | | | | | | | | | | | | | **Symptom** | | | | | | **YES** | | | | | | **NO** | | | | | | **UNK** | | | | | | **Symptom** | | | | | | **YES** | | | | **NO** | | | | **UNK** | | **Symptom** | | **YES** | | | | | | **NO** | | **UNK** |
|  | | | | | | | | |  | | | | | | | | | | | | | | Fever | | | | | |  | | | | | |  | | | | | |  | | | | | | Malaise | | | | | |  | | | |  | | | |  | | Headache | |  | | | | | |  | |  |
| DOB/Age: | | | | | | | | |  | | | | | | Sex: M  F | | | | | | | | Nausea | | | | | |  | | | | | |  | | | | | |  | | | | | | Vomiting | | | | | |  | | | |  | | | |  | | Anorexia | |  | | | | | |  | |  |
| Address(village name/nearest landmark): | | | | | | | | | | | | | | | | | | | | | | | Muscle spasm | | | | | |  | | | | | |  | | | | | |  | | | | | | Dysphasia | | | | | |  | | | |  | | | |  | | Ataxia | |  | | | | | |  | |  |
|  | | | | | | | | | | | | | | | | | | | | | | | Priapism | | | | | |  | | | | | |  | | | | | |  | | | | | | Seizures | | | | | |  | | | |  | | | |  | | Insomnia | |  | | | | | |  | |  |
|  | | | | | | | | | | | | | | | | | | | | | | | Anxiety | | | | | |  | | | | | |  | | | | | |  | | | | | | Confusion | | | | | |  | | | |  | | | |  | | Delirium | |  | | | | | |  | |  |
|  | | | | | | | | | | | | | | | | | | | | | | | Hypersalivation | | | | | |  | | | | | |  | | | | | |  | | | | | | Aerophobia | | | | | |  | | | |  | | | |  | | Hydrophobia | |  | | | | | |  | |  |
| Referring physician: | | | | | | | | | | | | | | | | | | | | | | | Aggressiveness | | | | | |  | | | | | |  | | | | | |  | | | | | | Agitation | | | | | |  | | | |  | | | |  | | Hyperactivity | |  | | | | | |  | |  |
|  | | | | | | | | | | | | | | | | | | | | | | | Localized pain/parasthesia | | | | | |  | | | | | |  | | | | | |  | | | | | | Localized weakness | | | | | |  | | | |  | | | |  | | Autonomic instability | |  | | | | | |  | |  |
|  | | | | | | | | | | | | | | | | | | | | | | | Additional comments: | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Number for physician: | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | Date of onset:\_\_/\_\_/\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | Patient alive? | | | | | | | | | | | If Not, Date death:\_\_/\_\_/\_\_\_\_ | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | | | |  | | | |
| EXPOSURE HISTORY *Tick appropriate box (yes; no; U: unknown)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PROPHYLAXIS/TREATMENT *Tick appropriate box (yes; no; UNK: unknown)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **YES** | | |  | | | | | | | | | | | | | | | | | | | | | | **NO** | | | **UNK** | | | | | | | | | **YES** | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | **NO** | | | | **UNK** | |
|  | | | **Patient bitten by animal?** | | | | | | | | | | | | | | | | | | | | | |  | | |  | | | | | | | | |  | | | | | | **Patient sought medical care after bite?** | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |  | |
|  | | | *If yes, Complete* | | | | | | | | | | | | | | | | | | | | | |  | | |  | | | | | | | | |  | | | | | | *If Yes, Complete* | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |  | |
|  | | | Date of exposure: | | | | | | | | | | | | | | | | | \_\_/\_\_/\_\_\_\_ | | | | | | | |  | | | | | | | | |  | | | | | | Date of treatment: | | | | | | | | | | | | | | | \_\_/\_\_/\_\_\_\_ | | | | | | | | | | | | | |  | |
|  | | | Place of exposure: | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | |  | | | | | | Health facility: | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |  | |
|  | | | Animal type | | | | | | | | | | | | | | | | | | | | | |  | | |  | | | | | | | | |  | | | | | | Patient wound treatment given? | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |  | |
| Dog | | | | | Cat | | | | | Mongoose | | | | | | | | | Bat | | jackal | Other (specify) | | | | | | | | | | | | | | |  | | | | | | | Has the victim had antibiotics (specify)? | | | | | | | | | | | | | | | | | | | | | | | | |  | | |  | |
|  | | Is the animal stray/strange? | | | | | | | | | | | | | | | | | | | | | | |  | | |  | | | | | | | | |  | | | | | | | Has the victim had tetanus vaccine | | | | | | | | | | | | | | | | | | | | | | | | |  | | |  | |
|  | | Is the animal still alive and healthy? | | | | | | | | | | | | | | | | | | | | | | |  | | |  | | | | | | | | |  | | | | | | | Patient rabies vaccine series given | | | | | | | | | | | | | | | | | | | | | | | | |  | | |  | |
|  | | Has the animal been killed? | | | | | | | | | | | | | | | | | | | | | | |  | |  | | | | | | | | | |  | | | | | | | Dose 1 | | | | | | | \_\_/\_\_/\_\_\_\_ | | | | | | | | | | | | | | | | | |  | | |  | |
|  | | Is the animal been tested against rabies? | | | | | | | | | | | | | | | | | | | | | | |  | |  | | | | | | | | | |  | | | | | | | Dose 2 | | | | | | | \_\_/\_\_/\_\_\_\_ | | | | | | | | | | | | | | | | | |  | | |  | |
|  | | Is the animal vaccinated against rabies? | | | | | | | | | | | | | | | | | | | | | | |  | |  | | | | | | | | | |  | | | | | | | Dose 3 | | | | | | | \_\_/\_\_/\_\_\_\_ | | | | | | | | | | | | | | | | | |  | | |  | |
|  | | Nature of exposure | | | | | | | | | | | | | | | | | | | | | | |  | |  | | | | | | | | | |  | | | | | | | Dose 4 | | | | | | | \_\_/\_\_/\_\_\_\_ | | | | | | | | | | | | | | | | | |  | | |  | |
|  | | *Multiple bites* | | | | | | | | | | | |  | | | | | *Single bite* | | | |  | Scratches | | | | | | | | | | | | |  | | | | | | | | (Dose 5) | | | | | | (\_\_/\_\_/\_\_\_\_) | | | | | | | | | | | | | | | | | |  | | |  | |
|  | | Licks on broken skin/mucous areas | | | | | | | | | | | | | | | | | | | | | | https://encrypted-tbn0.gstatic.com/images?q=tbn:ANd9GcRANEubojuihZG3eVaBBxyGecRxIgMmQdQfi9cWXqavW0y__PiYkw | | | | | | |  | | | | | |  | | | | | | | | Patient Immunoglobulin administered? | | | | | | | | | | | | | | | | | | | | | | | |  | | |  | |
|  | | | | Provoked | | | | | | | |  | | | | | Unprovoked attack | | | | | | | | | | | | | |  | | | | |  | | | | | | | | | **Victim previously completed rabies vaccine?** | | | | | | | | | | | | | | | | | | | | | | | |  | | |  | |
| Body site: circle affected area/s or describe below | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |  | | | | | If Yes, Date vaccination: | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |  | | |  | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | **Patient is hospitalised?** | | | | | | | | | | | | | | | | | | | | | | | | |  | | |  | |
| Describe events which led to exposure? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | If Yes, Date admission:\_\_/\_\_/\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | Hospital: | |  | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Additional comments: | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
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| LABORATORY SUBMISSION *Tick if specimen sent for testing* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | CLINICAL PATHOLOGICAL FINDINGS Complete/attach laboratory reports | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **YES** | | | | | | **SPECIMEN** | | | | | | | | | | **DATE** | | | | | | | | | | | | | | | | **YES** | | | | | | | **TEST** | | | | | | | | | |  | | | | **DESCRIBE RESULTS** | | | | | | | | | | | | | **DATE** | | | | | | | |
|  | | | | | | Nuchal biopsy | | | | | | | | | | \_\_/\_\_/\_\_\_\_ | | | | | | | | | | | | | | | |  | | | | | | | WBC: | | | | | | | | | |  | | | |  | | | | | | | | | | | | | \_\_/\_\_/\_\_\_\_ | | | | | | | |
|  | | | | | | Saliva | | | | | | | | | | \_\_/\_\_/\_\_\_\_ | | | | | | | | | | | | | | | |  | | | | | | | Protein level: | | | | | | | | | |  | | | |  | | | | | | | | | | | | | \_\_/\_\_/\_\_\_\_ | | | | | | | |
|  | | | | | | CSF | | | | | | | | | | \_\_/\_\_/\_\_\_\_ | | | | | | | | | | | | | | | |  | | | | | | | MRI: | | | | | | | | | |  | | | |  | | | | | | | | | | | | | \_\_/\_\_/\_\_\_\_ | | | | | | | |
|  | | | | | | Blood | | | | | | | | | | \_\_/\_\_/\_\_\_\_ | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | |  | | | |  | | | | | | | | | | | | | \_\_/\_\_/\_\_\_\_ | | | | | | | |
| Additional findings: | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | |  | | | |  | | | | | | | | | | | | | \_\_/\_\_/\_\_\_\_ | | | | | | | |
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**POST COMPLETED FORM WITH SPECIMEN TO**:

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