|  |
| --- |
| **SUSPECTED HUMAN RABIES CASE HISTORY FORM** |
| Filled in by:  |       | Contact number: |       |
| Date:  | \_\_/\_\_/\_\_\_\_  | Information collected from:  |       |
|  |  |  |  |
| 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: |       |
|       |       |
|       |       |
|       |       |
|  | \ |
| 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:  |       | [ ]  |       |  |       | \_\_/\_\_/\_\_\_\_ |
|       | [ ]  |       |  |       | \_\_/\_\_/\_\_\_\_ |
| n |  |  |  |  |

**POST COMPLETED FORM WITH SPECIMEN TO**:

Special Viral Pathogens Lab, National Institute for Communicable Diseases, National Health Laboratory Service, 1 Modderfontein Road, Sandringham 2192, South Africa**FAX OR EMAIL COMPLETED FORM TO:** 0865964423 or cezd@nicd.ac.za