NATIONAL INSTITUTE FOR COMMUNICABLE DISEASES
Division in the National Health Laboratory Service

Special Viral Pathogens Laboratory: +2711 386 6336 (or +2782 903 9131)
NICD Hotline for Clinical Advice: +27 800 212 552

SUSPECTED HUMAN RABIES CASE HISTORY FORM

Filled in by: _____ Contact number: _____
Date: __/__/____ Information collected from: _____

PATIENT INFORMATION

Name: _____

DOB/Age: _____ Sex: M ☐ F ☐

Address(village name/nearest landmark):

Referring physician:

Number for physician:

CLINICAL FEATURES *Tick appropriate box (yes; no, UNK: unknown)*

Symptom	YES	NO	UNK	Symptom	YES	NO	UNK	Symptom	YES	NO	UNK
Fever	☐	☐	☐	Malaise	☐	☐	☐	Headache	☐	☐	☐
Nausea	☐	☐	☐	Vomiting	☐	☐	☐	Anorexia	☐	☐	☐
Muscle spasm	☐	☐	☐	Dysphasia	☐	☐	☐	Ataxia	☐	☐	☐
Priapism	☐	☐	☐	Seizures	☐	☐	☐	Insomnia	☐	☐	☐
Anxiety	☐	☐	☐	Confusion	☐	☐	☐	Delirium	☐	☐	☐
Hypersalivation	☐	☐	☐	Aerophobia	☐	☐	☐	Hydrophobia	☐	☐	☐
Aggressiveness	☐	☐	☐	Agitation	☐	☐	☐	Hyperactivity	☐	☐	☐
Localized pain/parasthesia	☐	☐	☐	Localized weakness	☐	☐	☐	Autonomic instability	☐	☐	☐

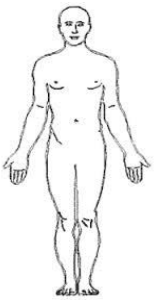
Additional comments:

Date of onset:__/__/____ Patient alive? ☐ If Not, Date death:__/__/____

EXPOSURE HISTORY *Tick appropriate box (yes; no; U: unknown)*

YES		NO	UNK
☐	**Patient bitten by animal?**	☐	☐
	If yes, Complete		
	Date of exposure: __/__/____		
	Place of exposure: _____		
	Animal type		
☐	Dog ☐ Cat ☐ Mongoose ☐ Bat ☐ jackal ☐ Other (specify) _____		
☐	Is the animal stray/strange?	☐	☐
☐	Is the animal still alive and healthy?	☐	☐
☐	Has the animal been killed?	☐	☐
☐	Is the animal been tested against rabies?	☐	☐
☐	Is the animal vaccinated against rabies?	☐	☐
	Nature of exposure		
☐	*Multiple bites* ☐ *Single bite* ☐ Scratches		
☐	Licks on broken skin/mucous areas		
☐	Provoked ☐ Unprovoked attack		

Body site: circle affected area/s or describe below



Describe events which led to exposure?

PROPHYLAXIS/TREATMENT *Tick appropriate box (yes; no; UNK: unknown)*

YES		NO	UNK
☐	**Patient sought medical care after bite?**	☐	☐
	If Yes, Complete		
	Date of treatment: __/__/____		
	Health facility: _____		
☐	Patient wound treatment given?	☐	☐
☐	Has the victim had antibiotics (specify)? _____	☐	☐
☐	Has the victim had tetanus vaccine	☐	☐
☐	Patient rabies vaccine series given	☐	☐
☐	Dose 1 (d 0) __/__/____	☐	☐
☐	Dose 2 (d 3) __/__/____	☐	☐
☐	Dose 3 (d 7) __/__/____	☐	☐
☐	Dose 4 (d14) __/__/____	☐	☐
☐	Patient Immunoglobulin administered?	☐	☐
☐	**Victim previously completed rabies vaccine?**	☐	☐
	If Yes, Date vaccination: _____		
☐	**Patient is hospitalised?**	☐	☐

If Yes, Date admission:__/__/____ Hospital: _____

Additional comments:

LABORATORY SUBMISSION *Tick if specimen sent for testing*

YES	SPECIMEN	DATE
☐	Saliva	__/__/____
☐	Brain	__/__/____
☐	Nuchal biopsy	__/__/____
☐	CSF	__/__/____

Additional findings:

CLINICAL PATHOLOGICAL FINDINGS Complete/attach laboratory reports

YES	TEST	DESCRIBE RESULTS	DATE
☐	WBC:		__/__/____
☐	Protein level:		__/__/____
☐	MRI:		__/__/____
☐	_____		__/__/____
☐	_____		__/__/____
☐	_____		__/__/____

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

EMAIL COMPLETED FORM TO:
jacquelinew@nicd.ac.za or
naazneenm@nicd.ac.za