North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch

North Carolina Public Health

ATTENTION HEALTH CARE PROVIDERS:
Please report relevant clinical findings about this disease event to the local health department.

RABIES, HUMAN
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 33

ATTENTION Local Health Department Staff: There is no Part 2 Wizard for this disease. Enter all information from this form into the NC EDSS question packages.

If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						SSN

NC EDSS LAB RESULTS Verify if lab results for this event are in NC EDSS. If not present, enter results.

Specimen Date	Specimen #	Specimen Source	Type of Test	Test Result(s)	Description (comments)	Result Date	Lab Name—City/State
/ /						/ /	
/ /						/ /	
/ /						/ /	

CLINICAL FINDINGS

Is/was patient symptomatic for this disease? ☐Y ☐N ☐U
If yes, symptom onset date (mm/dd/yyyy): __/__/____
Fever ☐Y ☐N ☐U
☐Yes, subjective ☐No
☐Yes, measured ☐Unknown
How was temperature taken? _____
Highest measured temperature_____
Date of highest measured temperature: ____/____/____
Fever onset date (mm/dd/yyyy):____/____/____
Fatigue or malaise or weakness ☐Y ☐N ☐U
Altered mental status ☐Y ☐N ☐U
Patient displayed:
☐Confusion ☐Agitation
☐Delirium ☐Combativeness
☐Coma ☐Excitability
☐Anxiety/apprehension ☐Hallucinations
Headache ☐Y ☐N ☐U
Encephalitis ☐Y ☐N ☐U
Seizures/convulsions ☐Y ☐N ☐U
Ataxia ☐Y ☐N ☐U
Autonomic instability ☐Y ☐N ☐U
Pain/sensory changes around location of animal bite ☐Y ☐N ☐U
Insomnia ☐Y ☐N ☐U
Hypersalivation ☐Y ☐N ☐U
Aversion to water (hydrophobia) ☐Y ☐N ☐U
Aversion to air on face (aerophobia) ☐Y ☐N ☐U
Cranial nerve or bulbar weakness or paralysis ☐Y ☐N ☐U
Difficulty swallowing (dysphagia) ☐Y ☐N ☐U
Muscle weakness (paresis) ☐Y ☐N ☐U
Muscle paralysis ☐Y ☐N ☐U
Nausea ☐Y ☐N ☐U
Vomiting ☐Y ☐N ☐U
Priapism (persistent erection) ☐Y ☐N ☐U

PREDISPOSING CONDITIONS

Any immunosuppressive conditions? ☐Y ☐N ☐U
Specify:_____
Injury/Wound/Break in skin ☐Y ☐N ☐U
Recent/Acute injury(ies) or wound(s) ☐Y ☐N ☐U
Date (mm/dd/yyyy):____/____/____
Anatomic site_____
Circumstances _____
_____
Principal wound type:
☐Animal bite
☐Other (e.g. with cancer)
☐Unknown

HOSPITALIZATION INFORMATION

Was patient hospitalized for this illness >24 hours? ☐Y ☐N ☐U
Hospital name: _____
City, State:_____
Hospital contact name: _____
Telephone: (_____) _____ - _____
Admit date (mm/dd/yyyy): ____/____/____
Discharge date (mm/dd/yyyy):____/____/____

CLINICAL OUTCOMES

Discharge/Final diagnosis:_____
_____
Survived? ☐Y ☐N ☐U
Died? ☐Y ☐N ☐U
Died from this illness? ☐Y ☐N ☐U
Date of death (mm/dd/yyyy):_____/_____/_____
Autopsy performed? ☐Y ☐N ☐U
Facility where autopsy was performed
_____
Patient autopsied in NC? ☐Y ☐N ☐U
County of autopsy:_____
Source of death information:
☐Death certificate
☐Autopsy report final conclusion
☐Hospital/physician discharge
☐Other
Date of death (mm/dd/yyyy):____/____/____
NOTE: The death certificate, autopsy report, hospital/physician discharge summary, and/or other documentation should be attached.

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
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TREATMENT

Was rabies post-exposure prophylaxis recommended? ☐Y ☐N ☐U

By whom:
- ☐ Public health veterinarian
- ☐ Public health physician
- ☐ Public health nurse
- ☐ Private healthcare provider
- ☐ Other
- ☐ Unknown

Was rabies post-exposure prophylaxis (PEP) given? ☐Y ☐N ☐U

Date PEP initiated (mm/dd/yyyy):____/____/____

Patient previously vaccinated ☐Y ☐N ☐U

Date vaccinated (mm/dd/yyyy):____/____/____

Specify type of PEP:
- ☐ Human rabies immune globulin (RIG) and 5 vaccines
- ☐ 2 vaccines (booster)
- ☐ Unknown

Continuing vaccinations begun in another county/state? ☐Y ☐N ☐U

Who supplied PEP? (check all that apply)
- ☐ State HD
- ☐ LHD
- ☐ Private MD
- ☐ Other
- ☐ Unknown

Who administered PEP? (check all that apply)
- ☐ LHD
- ☐ Private MD
- ☐ Other
- ☐ Unknown

Did patient sign a consent/declination form for rabies PEP? ☐Y ☐N ☐U

Did the patient receive medical care for this illness? ☐Y ☐N ☐U

Specify level(s) of care (check all that apply):
- ☐ Outpatient
- ☐ Emergency department
- ☐ Inpatient
- ☐ ICU
- ☐ Other
- ☐ Unknown

Did the patient require supplemental oxygen? ☐Y ☐N ☐U

Did the patient require mechanical ventilation? ☐Y ☐N ☐U

TRAVEL & IMMIGRATION

The patient is:
- ☐ Resident of NC
- ☐ Resident of another state or US territory
- ☐ None of the above

Did patient have a travel history during the 3-8 weeks prior to onset of symptoms? ☐Y ☐N ☐U

List travel dates and destinations:

From _____/_____/_____ to _____/_____/_____

_____

_____

Does patient know anyone else with similar symptom(s) who had the same or similar travel history? ☐Y ☐N ☐U

List persons and contact information:

_____

_____

HEALTH CARE FACILITY AND BLOOD & BODY FLUID EXPOSURE RISKS

During the 3-8 weeks prior to onset of symptoms, did the patient have blood or body fluid exposures? ☐Y ☐N ☐U

☐ **Transplant recipient (tissue / organ / bone / bone marrow)**

Date received (mm/dd/yyyy):____/____/____

Type of donation / transplant_____

Provider name_____

Contact name at facility_____

Facility name_____

City_____State _____

Country _____

OTHER EXPOSURE INFORMATION

Does the patient know anyone else with similar symptoms? ☐Y ☐N ☐U

Specify _____

Has the patient ever served in the U.S. military? ☐Y ☐N ☐U

If yes, dates of service:

From _____ to_____

OUTDOOR EXPOSURE

During the 3-8 weeks prior to onset of symptoms, did the patient participate in any outdoor activities? ☐Y ☐N ☐U

If yes, specify and give details:

Was patient exposed to wild animals? ☐Y ☐N ☐U

If yes, specify and give details:

Did patient sleep outside in open? ☐Y ☐N ☐U

If yes, specify and give details:

Did patient sleep in tent or cabin? ☐Y ☐N ☐U

If yes, specify and give details:

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						SSN

ANIMAL EXPOSURE

During the 3-8 weeks prior to onset of symptoms, did the patient have exposure to animals (includes animal tissues, animal products, or animal excreta)**?** ☐ Y ☐ N ☐ U

Household pets? ☐ Y ☐ N ☐ U

Specify pet(s) _____

Was pet vaccinated for rabies? ☐ Y ☐ N ☐ U

Was pet sick? ☐ Y ☐ N ☐ U

Was pet free-ranging? ☐ Y ☐ N ☐ U

Did patient own, work at, or visit a pet store, animal shelter, and/or animal breeder/wholesaler/ distributor? ☐ Y ☐ N ☐ U

Specify:
- ☐ Owned
- ☐ Worked
- ☐ Visited

Business name _____

Street address _____

City _____

State _____ Zip code _____

Exposed on (mm/dd/yyyy): ____/____/____

Until (mm/dd/yyyy): ____/____/____

Frequency
- ☐ Once
- ☐ Multiple times within this time period
- ☐ Daily

Did the patient handle any animals? ☐ Y ☐ N ☐ U

Species: _____

Did it/they appear sick? ☐ Y ☐ N ☐ U

Did patient work with animal importation? ☐ Y ☐ N ☐ U

Business address _____

City _____

State _____ Zip code _____

Species _____

Country of origin _____

Shipping port of origin (if known) _____

Did patient / household contact work at, live on, or visit a farm, ranch, or dairy? ☐ Y ☐ N ☐ U

Specify:
- ☐ Worked
- ☐ Lived on
- ☐ Lived with someone who worked/visited
- ☐ Visited

Farm/ranch/dairy name _____

Street address _____

City _____

State _____ Zip code _____

County _____

Telephone (_____) _____

Exposed on (mm/dd/yyyy): ____/____/____

Until (mm/dd/yyyy): ____/____/____

Frequency
- ☐ Once
- ☐ Multiple times within this time period
- ☐ Daily

Was patient exposed to animals associated with agriculture (domestic/semi-domestic animals)? ☐ Y ☐ N ☐ U

Specify animal(s): _____

_____

Exposed on (mm/dd/yyyy): ____/____/____

Until (mm/dd/yyyy): ____/____/____

Frequency:
- ☐ Once
- ☐ Multiple times within this time period
- ☐ Daily

Did the patient work at or visit a fair with livestock or a petting zoo? ☐ Y ☐ N ☐ U

Visited or worked?
- ☐ Visited ☐ Worked

Specify contact/exposure to agricultural livestock
- ☐ Cattle ☐ Sheep
- ☐ Horses ☐ Swine
- ☐ Goats ☐ Other _____

Fair/petting zoo name _____

Street address _____

City _____

State _____ Zip code _____

County _____

Telephone (_____) _____

Did the patient work at or visit a zoo, zoological park, or aquarium? ☐ Y ☐ N ☐ U

Visited or worked?
- ☐ Visited
- ☐ Worked

Specify contact/exposure to any agricultural livestock present at facility:
- ☐ Cattle ☐ Sheep
- ☐ Horses ☐ Swine
- ☐ Goats ☐ Other

Zoo or Aquarium name _____

Street address _____

City _____

State _____ Zip code _____

County _____

Telephone (_____) _____

Did patient work in a veterinary practice or animal laboratory, animal research setting, biomedical laboratory, or an animal diagnostic laboratory? ☐ Y ☐ N ☐ U

Which type of work setting?
- ☐ Animal diagnostic (pathology) laboratory
- ☐ Animal laboratory/animal research
- ☐ Biomedical laboratory
- ☐ Research involving animals
- ☐ Veterinary medical practice

Name of facility _____

Street address _____

City _____

State _____ Zip code _____

County _____

Telephone (_____) _____

Specify species: _____

Did patient work with rabies vaccine production? ☐ Y ☐ N ☐ U

Did patient necropsy animals? ☐ Y ☐ N ☐ U

Specify species: _____

RABIES EXPOSURE

During the 3-8 weeks prior to onset of symptoms, was the patient known to be or potentially exposed to a rabid animal? ☐ Y ☐ N ☐ U

If yes, type of exposure
- ☐ Bite (any penetration of the skin by teeth)
- ☐ Non-bite (contamination of open wound, abrasion, mucous membrane or scratch with saliva or other potentially infectious material, such as nervous tissue)
- ☐ Cryptic / presumed (no known exposure to saliva; i.e. bat found in house, bat found in sleeping area, aerosol exposure such as caves)
- ☐ Unknown

On (mm/dd/yyyy): ____/____/____

Until (mm/dd/yyyy): ____/____/____

Frequency
- ☐ Once
- ☐ Multiple times within this time period
- ☐ Daily

Circumstances of exposure _____

_____

Location of wound on body (anatomic site: hand, arm, leg, etc.) _____

Was wound cleaned? ☐ Y ☐ N ☐ U

Sought medical attention & treatment? ☐ Y ☐ N ☐ U

Exposure location (where exposure occurred)
- ☐ In North Carolina
  - County _____
- ☐ Outside North Carolina, but in US
  - State _____
- ☐ Outside US
  - Country _____

Was the animal wild? ☐ Y ☐ N ☐ U

Specify animal _____
- ☐ Unknown animal species

Was the animal captured for testing? ☐ Y ☐ N ☐ U

If yes, DFA result
- ☐ Positive ☐ Negative ☐ Inconclusive

Laboratory name _____

Street address _____

City _____ State _____

Zip code _____

Telephone (_____) _____

Was the animal a domestic animal or pet? ☐ Y ☐ N ☐ U

Specify animal _____

Was the animal vaccinated? ☐ Y ☐ N ☐ U

Date of animals last rabies vaccine: ____/____/____

Total number of doses _____

Is animal undergoing 10-day confinement? ☐ Y ☐ N ☐ U

Date entered 10-day confinement: ____/____/____

Is 10-day confinement complete? ☐ Y ☐ N ☐ U

Date completed 10-day confinement: ____/____/____

Was animal dead or alive at time of exposure?
- ☐ Status unknown ☐ Dead ☐ Alive

Did the animal appear sick or exhibit abnormal behavior? ☐ Y ☐ N ☐ U

Describe behavior(s)
- ☐ Lethargic
- ☐ Aggressive
- ☐ Salivating
- ☐ Staggering or have abnormal gait

Did animal attack animal(s) or person(s)? ☐ Y ☐ N ☐ U

If yes, was the animal provoked? ☐ Y ☐ N ☐ U

Animal-related notes:

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						SSN

CASE INTERVIEWS/INVESTIGATIONS

Was the patient interviewed? ☐ Y ☐ N ☐ U

Date of interview (mm/dd/yyyy):_____/_____/_____

Were interviews conducted with others? ☐ Y ☐ N ☐ U

Who was interviewed?

Were health care providers consulted? ☐ Y ☐ N ☐ U

Who was consulted?

Medical records reviewed (including telephone review with provider/office staff)? ☐ Y ☐ N ☐ U

Specify reason if medical records were not reviewed:

Notes on medical record verification:

GEOGRAPHICAL SITE OF EXPOSURE

In what geographic location was the patient MOST LIKELY exposed?

Specify location:

☐ In NC

City _____

County _____

☐ Outside NC, but within US

City _____

State _____

County _____

☐ Outside US

City _____

Country _____

☐ Unknown

Is the patient part of an outbreak of this disease? ☐ Y ☐ N

Notes:

VACCINE

Has patient/contact ever received rabies vaccine ☐ Y ☐ N ☐ U

☐ Known vaccine type,

specify _____

☐ Unknown vaccine type

☐ Rabies Immune Globulin (RIG)

Number of doses received? _____

Date(s) of doses: _____

How many days prior to illness onset was vaccine received?

☐ Fewer than 14 days ☐ 14 days or more

Prescribing healthcare provider name _____

Prescribing healthcare provider telephone (_____) _____

Was vaccination pre-exposure or post-exposure?

☐ Pre-exposure ☐ Post-exposure

Source of vaccine information:

☐ Patient's or Parent's verbal report

☐ Physician

☐ Medical record *(Note: Any vaccine on a medical record should be recorded in the NCIR)*

☐ Certificate of immunization record *(Note: Any vaccine on a certificate of immunization should be recorded in the NCIR)*

☐ Patient vaccine record

☐ School record

☐ Other, specify: _____

☐ Unknown

Rabies, Human

2011 Case Definition

CSTE Position Statement Number: 10-ID-16

Clinical evidence

Rabies is an acute encephalomyelitis that almost always progresses to coma or death within 10 days after the first symptom.

Laboratory evidence

- 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.