Animal Rabies (Human Contacts) Report Form

INTERVIEW

EpiTrax # __________________________ Interviewer Name:__________________________________________________________

DEMOGRAPHICS

Name: ________________________________ County: ________________________________
Address: ________________________________ Date of Birth: ________________________________
Telephone Number: ________________________________

Birth Gender: □ Male □ Female Hispanic/Latino Origin: □ Yes □ No □ Unknown

How would you describe your race?
□ White □ Black/African American □ American Indian/Alaska Native
□ Asian □ Native Hawaiian/Other Pacific Islander □ Other, Specify: __________
□ Unknown

Disposition: □ Preventive Treatment □ Refused Preventative Treatment
□ Insufficient Information to Begin Investigation □ Unable to Locate
□ Other, Specify: __________ Disposition Date: ______________

Contact Type: □ Healthcare / Healthcare worker □ Household
□ Laboratory worker □ Non-household family
□ First responder □ Schools/Daycare
□ Social □ Work
□ Other, Specify: ________________
A. Exposure

Type of Exposure:  
☐ Bite  
☐ Non-bite (scratch or abrasion)  
☐ Non-bite (contamination of open cut with saliva or nervous tissue)  
☐ No exposure (petting, handling, blood contact)

Specify exposure site:
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

Was the exposure provoked or unprovoked?  
☐ Provoked  ☐ Unprovoked

Describe exposure incident:
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

Provide address where exposed:
______________________________________________________________________________________________
______________________________________________________________________________________________

B. Exposure Treatment

Was the person previously vaccinated against rabies?  
☐ Yes; date of last vaccination ________________  
☐ No  
☐ Unknown

Based on the exposure assessment, was PEP recommended by LHD or KDHE?  
☐ Yes  
☐ No
Was rabies PEP started?

- ☐ No, not recommended
- ☐ No, recommended but patient refused
  - Was recommendation letter sent to the patient?
    - ☐ Yes; date sent ____________
    - ☐ No
- ☐ No, recommended and patient did not refuse
  - Specify why PEP was not started: ____________________________________________
    ____________________________________________

- ☐ Yes, PEP started
  - Who made the final recommendation on rabies PEP?
    - ☐ Healthcare provider
    - ☐ Local health department
    - ☐ Local health officer
    - ☐ Other, specify ____________
  - Where was rabies PEP received?
    - ☐ Emergency room
    - ☐ Physician’s office
    - ☐ Local health department
    - ☐ Urgent care
  - Was the series completed?
    - ☐ Yes
    - ☐ No
    - If not, reason:
      - ☐ Animal tested negative
      - ☐ Patient refused further treatment
      - ☐ Patient lost to follow-up
      - ☐ Other, specify________

  - Payment source?
    - ☐ Private insurance
    - ☐ Medicaid
    - ☐ Worker’s compensation
    - ☐ Out-of-pocket
    - ☐ Private source
    - ☐ No source

Was tetanus containing vaccine recommended due to this exposure? ☐ Yes ☐ No ☐ Up-to-date

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**CLINICAL**

Was treatment given? ☐ Yes ☐ No  (If no, skip this CLINICAL section)
<table>
<thead>
<tr>
<th>Treatment Type</th>
<th>☐ Yes</th>
<th>No</th>
<th>If yes, date given: ________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rabies Immune Globulin</td>
<td></td>
<td></td>
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<tr>
<td>Human Rabies Vaccine Dose 1 (Day 0)</td>
<td>☐</td>
<td></td>
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<tr>
<td>Human Rabies Vaccine Dose 2 (Day 3)</td>
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<tr>
<td>Human Rabies Vaccine Dose 3 (Day 7)</td>
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<tr>
<td>Human Rabies Vaccine Dose 4 (Day 14)</td>
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<tr>
<td>Human Rabies Vaccine Dose 5 (Day 21)</td>
<td>☐</td>
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</tbody>
</table>

* For those with immunosuppression

Clinician (Last name, First name): __________________________________________________________

Telephone: ______________________

Facility Name: __________________________________________________________

Address: ______________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________