December 2020

NJDOH HUMAN RABIES INVESTIGATION WORKSHEET

MR #: _____ CDRSS #: _____

DEMOGRAPHICS

Patient Last Name	First Name	DOB:	Phone number
		____ / ____ / ____	

Address	City	Municipality

Race

☐White ☐Black ☐ American Indian or Alaskan Native
☐Asian ☐ Pacific Islander/Native Hawaiian ☐ Other_____

Ethnicity

◯ Hispanic
◯ Non-Hispanic
◯ Unknown

Country of Birth

Pregnancy status

◯Pregnant
Due Date: ____ / ____ / ___
◯Not Pregnant
◯Unknown
◯N/A

Occupation

Does the patient have an immunosuppressive condition?

☐ Yes ◯No ◯Unk

If yes, specify:

CLINICAL INFORMATION

Treating physician

Name:
Address:
Phone: Fax:
Email:

Facility (if hospitalized)

Name of facility:
Date of admission: ___ /___ /_____
Date of discharge: ___ /___ /_____

Admitting Diagnosis	Current Diagnosis	Onset Date
		_____ / _____ / _____

Summary of initial signs and/or symptoms at presentation:

Was patient previously hospitalized or ED visit for current illness?

◯Yes ◯No ◯Unk

Facility:
Date(s): ___ /___ /_____ to ___ /___ /_____
ED or inpatient?

Select a response for each sign or symptom below and include onset date

Sign/Symptom	Response	Onset Date	Additional Information / Description
Abdominal pain	◯Yes ◯No ◯Unk	___ /___ /_____	
Aerophobia	◯Yes ◯No ◯Unk	___ /___ /_____	
Agitation or aggression	◯Yes ◯No ◯Unk	___ /___ /_____	
Anorexia	◯Yes ◯No ◯Unk	___ /___ /_____	
Anxiety	◯Yes ◯No ◯Unk	___ /___ /_____	
Aphasia or dysarthria	◯Yes ◯No ◯Unk	___ /___ /_____	
Ataxia	◯Yes ◯No ◯Unk	___ /___ /_____	
Autonomic instability	◯Yes ◯No ◯Unk	___ /___ /_____	
Chest pain	◯Yes ◯No ◯Unk	___ /___ /_____	
Confusion or delirium	◯Yes ◯No ◯Unk	___ /___ /_____	
Cough or dyspnea	◯Yes ◯No ◯Unk	___ /___ /_____	
Dysphagia	◯Yes ◯No ◯Unk	___ /___ /_____	
Fever (≥ 38.0°C, 100.4°CF)	◯Yes ◯No ◯Unk	___ /___ /_____	Tmax: _____F

Hallucinations	○Yes ○No ○Unk	___ /___ /_____	
Headache	○Yes ○No ○Unk	___ /___ /_____	
Hydrophobia	○Yes ○No ○Unk	___ /___ /_____	
Hypersalivation	○Yes ○No ○Unk	___ /___ /_____	
Insomnia	○Yes ○No ○Unk	___ /___ /_____	
Localized weakness	○Yes ○No ○Unk	___ /___ /_____	
Malaise or fatigue	○Yes ○No ○Unk	___ /___ /_____	
Muscle spasm	○Yes ○No ○Unk	___ /___ /_____	
Nausea or vomiting	○Yes ○No ○Unk	___ /___ /_____	
Paresthesia or localized pain	○Yes ○No ○Unk	___ /___ /_____	
Photophobia / Blurred vision	○Yes ○No ○Unk	___ /___ /_____	
Priapism or spontaneous ejaculation	○Yes ○No ○Unk	___ /___ /_____	
Seizures	○Yes ○No ○Unk	___ /___ /_____	
Sore throat	○Yes ○No ○Unk	___ /___ /_____	
Stiff neck	○Yes ○No ○Unk	___ /___ /_____	
Other:		___ /___ /_____	

Is the patient in the ICU?	**Is the patient intubated?**	**Is the patient in a coma?**	**Did the patient die?**
○Yes Date: ___ /___ /_____ ○No ○Unk	○Yes Date: ___ /___ /_____ ○No ○Unk	○Yes Date: ___ /___ /_____ ○No ○Unk	○Yes Date: ___ /___ /_____ ○No ○Unk

CLINICAL TESTING

Brain CT

Date: _____ / _____ / _____

Findings: ○Normal ○Abnormal ○Not done

If abnormal:

- ☐Temporal lobe
- ☐Hydrocephalus
- ☐Severe cerebral edema
- ☐White matter demyelination
- ☐Other: _____

Brain MRI

Date: _____ / _____ / _____

Findings: ○Normal ○Abnormal ○Not done

If abnormal:

- ☐Temporal lobe
- ☐Hydrocephalus
- ☐Severe cerebral edema
- ☐White matter demyelination
- ☐Other: _____

EEG

Date: _____ / _____ / _____

Findings: ○Normal ○Abnormal ○Not done

If abnormal:

- ☐Diffuse slowing
- ☐Temporal epileptiform activity
- ☐PLEDS
- ☐Other: _____

CSF Analysis

Date: _____ / _____ / _____

Findings: ○Normal ○Abnormal ○Not done

Protein:

Glucose:

RBC:

WBC:

Diff:

Segs: _____ *Monos:*_____ *Bands:* _____

*Lymph:*_____ *Eos:*_____

CBC Analysis:

Date: _____ / _____ / _____

Findings: ○Normal ○Abnormal ○Not done

WBC:

HCT:

Platelets:

Diff:

Segs: _____ *Monos:*_____ *Bands:* _____

*Lymph:*_____ *Eos:*_____

Microbiology studies	Result				Specimen collection date
HSV CSF PCR	Negative	Positive	Not done	Pending	_____ / _____ / _____
Varicella CSF PCR	Negative	Positive	Not done	Pending	_____ / _____ / _____
CMV CSF PCR	Negative	Positive	Not done	Pending	_____ / _____ / _____
Enterovirus CSF PCR	Negative	Positive	Not done	Pending	_____ / _____ / _____
CrAg CSF	Negative	Positive	Not done	Pending	_____ / _____ / _____
VDRL CSF	Negative	Positive	Not done	Pending	_____ / _____ / _____

Arbovirus Panel	Not Done	Pending	Serum IgM (+/-)	Serum IgG (+/-)	CSF IgM (+/-)	CSF IgG (+/-)
West Nile Virus						
St. Louis encephalitis						
Eastern Equine encephalitis						
Western Equine encephalitis						
California encephalitis						
La Crosse encephalitis						

Other microbiological studies/ results:

Other Labs / Imaging	Result / Status: Normal	Abnormal	Not done	Pending	Value (Qualitative)	Date of test
Na/K	☐	☐	☐	☐		
BUN/Cr	☐	☐	☐	☐		
AST/ALT	☐	☐	☐	☐		
Alk Phos	☐	☐	☐	☐		
INR/PTT	☐	☐	☐	☐		
Glucose	☐	☐	☐	☐		
ESR	☐	☐	☐	☐		
ANA	☐	☐	☐	☐		
CXR	☐	☐	☐	☐		
Tox. screen	☐	☐	☐	☐		

Other:

TREATMENT

Treatment type	Response	Name of product	Date of administration
Rabies immunoglobulin	Yes No Unk		_____ / _____ / _____
Rabies vaccine, dose 1	Yes No Unk		_____ / _____ / _____
Rabies vaccine, dose 2	Yes No Unk		_____ / _____ / _____
Rabies vaccine, dose 3	Yes No Unk		_____ / _____ / _____
Rabies vaccine, dose 4	Yes No Unk		_____ / _____ / _____
Antiviral agents	Yes No Unk		_____ / _____ / _____
Steroids / IVIG	Yes No Unk		_____ / _____ / _____

Other medications (including OTC and herbal):

Recent vaccinations and dates of administration:

RISK FACTORS - 12 MONTH HISTORY FROM ILLNESS ONSET	
Did the patient have an animal exposure in the past 12 months? Yes No Unk	Animal species: Date of exposure: _____ / _____ / _____ Describe exposure:
Did this patient have an arthropod contact in the past 12 months? Yes No Unk	Animal species: Date of contact: _____ / _____ / _____ Describe contact (bite?):
Did the patient engage in outdoor activities (e.g., camping, hiking) in the past 12 months? Yes No Unk	Describe activity: Date(s) of activity:
Did the patient travel domestically in the past 12 months? Yes No Unk	Location(s): Dates:
Did the patient travel internationally in the past 12 months? Yes No Unk	Location(s): Dates:
Provide information on any other pertinent exposures in the last 12 months (e.g., day care, head trauma, sick contacts, TB exposures)	Describe exposures and dates of exposures:

ADDITIONAL CASE NOTES