BC Centre for Disease Control
AN AGENCY OF THE PROVINCIAL HEALTH SERVICES AUTHORITY

Rabies Exposure Case Report Form

Confidential when completed. VCH-please fax completed forms to BCCDC at 604-707-2516

PERSON REPORTING	
Health Authority:	☐ FHA ☐ IHA ☐ VIHA ☐ NHA ☐ VCH
Name:	*Last* *First*
Phone:	( ) - ext.
Email:	

A. CLIENT INFORMATION

Name: *Last* *First* *Middle*

PHN:	Date of Birth: *YYYY / MM / DD*	Sex: ☐ Male ☐ Female
Home Address: *Unit #* *Street #* *Street Name*		City:
Postal code:	Province:	
Phone number *(home)*:	Phone number *(work)*:	Phone number *(other)*:

Interview conducted with:

Self-reported weight (kg):

Has client previously received rabies pre-exposure immunization?

☐ Yes - complete ☐ Yes - partial ☐ No ☐ Unknown

If yes, specify immunization date: _____ *YYYY / MM / DD* Vaccine type: _____

Has client previously received complete post-exposure prophylaxis?

☐ Initiated ☐ Complete ☐ Not started ☐ Unknown

If yes, specify date of last dose: _____ *YYYY / MM / DD* Vaccine type: _____

Is client immunocompromised? ☐ Yes ☐ No ☐ Unknown

If yes, specify: _____

Is client on chloroquine? ☐ Yes ☐ No ☐ Unknown

B. ABORIGINAL INFORMATION

Do you wish to self-identify as an Aboriginal Person? ☐ Asked, not provided ☐ No ☐ Not asked ☐ Yes

Aboriginal Identity: ☐ Asked, but unknown ☐ Asked, not provided ☐ First Nations ☐ First Nations and Inuit ☐ First Nations and Métis ☐ First Nations, Inuit and Métis ☐ Inuit ☐ Inuit and Métis ☐ Métis ☐ Not asked

First Nations Status: ☐ Asked, but unknown ☐ Asked, not provided ☐ Non-Status Indian ☐ Not Asked ☐ Status Indian

C. PHYSICIAN INFORMATION

Last Name:	First Name:
No. and Street Address:	Phone:
City/Town:	Postal Code:

D. EXPOSURE INFORMATION

Date of exposure: _____ *YYYY / MM / DD*

Date of report to public health: _____ *YYYY / MM / DD*

Place of exposure: ☐ Within BC ☐ Outside BC but within Canada ☐ Outside Canada

Place of exposure details (e.g., city, province, country): _____

Any bleeding or breaks to skin? ☐ Yes ☐ No ☐ Unknown

Type of exposure: ☐ Bite ☐ Scratch ☐ Saliva ☐ Handling ☐ Unknown ☐ Other: _____

Location of exposure: ☐ Head/neck ☐ Torso ☐ Extremities ☐ Finger ☐ Mucosa ☐ Unknown

☐ Other: _____

Exposure details: _____

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E. ANIMAL INFORMATION

Animal type: ☐ Bat ☐ Cat ☐ Dog ☐ Monkey♦ ☐ Unknown ☐ Other: _____

Is the monkey Macaque? ☐ Yes ☐ No ☐ Unknown

♦ If exposure was to a monkey, assess risk for Simian B virus. Refer to Communicable Disease Control Manual: Simian B virus

Domestication: ☐ Household pet - indoor ☐ Household pet - outdoor ☐ Stray ☐ Wild ☐ Unknown

Animal owner name: _____

Animal owner address: _____

_____

Animal description: _____

Animal immunized against rabies? ☐ Yes ☐ No ☐ Unknown

If yes, is immunization up-to-date? ☐ Yes ☐ No ☐ Unknown

Immunization date: _____ *YYYY / MM / DD*

Observation period following exposure? ☐ Yes ☐ No ☐ Unknown

Observation from date: _____ *YYYY / MM / DD* Observation to date: _____ *YYYY / MM / DD*

Observation location: _____

Marked change in animal health: ☐ Yes * ☐ No ☐ Unknown

Animal died: ☐ Yes ☐ No ☐ Unknown

*Symptoms: _____

*Onset date _____ *YYYY / MM / DD* ** If marked change in animal health, symptoms and onset date are required*

Vet name: _____ Phone: _____

Brain sent for testing? ☐ Yes ☐ No ☐ Unknown Date specimen shipped: _____ *YYYY / MM / DD*

Sample ID (as per CFIA rabies sample submission form): _____ Submitter (as per CFIA rabies sample submission form): _____

Date of test: _____ *YYYY / MM / DD* FA Result: ☐ Positive ☐ Negative ☐ Indeterminate

Lab comments: _____

_____

Client notified of results: ☐ Yes ☐ No ☐ Unknown Date client notified: _____ *YYYY / MM / DD*

F. PET EXPOSURE

Does client have a pet? ☐ Yes ☐ No ☐ Unknown

If yes, what species? _____

If pet(s) is a mammal, was pet exposed to suspect rabid animal? ☐ Yes ☐ No ☐ Unknown

If yes or unknown, advise the client to take the mammalian[1] pet to a veterinarian for assessment.

G. RABIES POST-EXPOSURE PROPHYLAXIS

Has client received rabies biologicals for current exposure? *If yes for either, please report details on form (VCH) or Panorama immunization module.*

RabIg ☐ Yes ☐ No ☐ Unknown

Date: _____ *YYYY / MM / DD* Location: _____

Rabies vaccine: ☐ Yes ☐ No ☐ Unknown

Date (yyyy/mm/dd)	Product name	Location received	Anatomical site

MHO recommended RPEP? ☐ Yes

RPEP authorized by: _____ (name of MHO)

Date authorized: _____ *YYYY / MM / DD*

MHO comments: _____

_____

Person who received authorization (print name): _____

I. Additional Details Related to Case Investigation

Date	Comment	Initials

[1] Only mammals are at risk of rabies infection.