Appendix 4. Rabies virus and other lyssaviruses (including ABLV) post-exposure prophylaxis form

RABIES VIRUS and OTHER LYSSAVIRUSES (including ABLV) POST EXPOSURE ASSESSMENT

Case details ID no. _______________

Name:____Sex M F Date of birth__/___/___

Address: ____ Phone: __________________

Indigenous status: Aboriginal____ Torres Strait Islander____Aboriginal and Torres Strait Islander____
Non-indigenous____ Unknown____

Person Notifying

Name ___________________________ Fax _________________

Clinic/hospital name (if relevant)_______________________________________

Address ___________________________ Telephone _________________

Suburb ____________ State ____________ Postcode _____________

Exposure

Date of exposure ____________ Time of exposure_________________

Type of wound Bite Scratch Lick Saliva Other _________________________

Wound/exposure location ______________________

Was the skin broken? Y N U Depth/Severity____________________________

Did the wound bleed? Y N U _______________________________________

Animal: Dog Cat Monkey Bat *Type*.................. Other *Specify*...................

Was the animal: Wild Domestic Unknown

Did the animal appear unwell? Y N U *If yes, describe*:________________________

Was the animal provoked? Y N U *Describe incident*:________________________

Is the animal's owner/home known? Y N U

When was the animal last seen alive? (date) ___/____/_____ Animal's vaccination status, if known________________________________

If tested, was the animal positive for rabies virus or another lyssavirus? Y N U

If yes, provide details: ____

Where did exposure occur? *(geographic location-as precise as possible)*

____

Country ____________________________

Case history

Did the case receive the wound during occupational (including volunteering) activity? Y N U

Did the case spend more than a month in a rabies enzootic area? Y N U

Was the case working with mammals in a rabies enzootic area? Y N U

Did the case work with live lyssavirus in a laboratory? Y N U

Previous rabies vaccination? Y N U Doses _____ Date of last dose _____

Which vaccine? ___________

Was immunoglobulin given? Y N U Date ____________

Describe treatment of wound following incident: ______________________________

Is the case immunocompromised? Y N U *If yes, details* ____________________

____

Treatment details (in Australia)

Date wound assessed __/__/____

Who assessed the wound? GP ED PHU Health Service Other _____________

RIG Date administered __/__/____ Weight of case ____ kg amount used _____mL

Vaccine Date of first dose __/__/____ Doses required____

Who will provide PEP *(if different to person notifying)* Name ________________________

Fax ______________

Clinic/hospital name (if relevant)__________________________________

Address ________________________ Telephone ________________

Suburb ________________ State ___________ Postcode ____________________

Jurisdictional contact

Name ________________________ Fax ________________

Address ________________________ Telephone ________________

Suburb ___________ State ___________ Postcode ____________