

## Appendix 4. Rabies and Australian bat lyssavirus post-exposure prophylaxis form

### RABIES and AUSTRALIAN BAT LYSSAVIRUS 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 or Australian bat 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 endemic area? Y N U

Was the case working with mammals in a rabies endemic 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 \_\_\_\_\_