Rabies Treatment

County ________ # ________ ___/___/___ Initial Report Date

Person Treated

Name ______________________________ Phone(s)______________
indicate home (H), work (W), or message (M)

Address ____
Street City State Zip

Age ______ Sex ☐ Female ☐ Male

Exposure Information

Exposure Date _____/____/___

Exposure Occurred in

City ________________________

County ______________________

State ________________________

Country ______________________

Type of Exposure

☐ Unknown
☐ Bite
☐ Saliva
☐ Scratch
☐ Bat in sleeping area
☐ Other

Description of Exposure

....
....
....
....
....
....
....

Animal Responsible for Exposure

Type of Animal

☐ Unknown
☐ Bat
☐ Dog
☐ Cat
☐ Ferret
☐ Other type ________________

Description (age, breed, relevant history)

....
....
....

Test Results

☐ Not tested
☐ Negative
☐ Unsatisfactory
☐ Positive
☐ Indeterminate

Laboratory

☐ WA State Public Health Lab.
☐ Seattle-King County Lab.
☐ CDC ☐ Other

Date Specimen Shipped ___/___/___

Animal Rabies Vaccine History

☐ Unknown
☐ Unvaccinated
☐ Vaccinated, current
☐ Vaccinated, not current *

Last shot given ___/___/___

Manufacturer ________________

* Rabies booster vaccine not given at recommended time (one year or three years) after previous vaccination depending on vaccine type.

Post-Exposure Rabies Prophylaxis

Initial Treatment Date

____/____/____

Number of Other Persons Treated Related to this Exposure Incident

____

See report numbers ______________

____

Health Care Provider Who Administered Treatment

Name______________________________

Address____________________________

City/State__________________________

County_____________________________

Phone______________________________

Product Administered (rabies vaccine)

Name____________________

Lot Number _______________

Expiration Date ___/___/____

Product Administered (rabies immune globulin)

Name____________________

Lot Number _______________

Expiration Date ___/___/____

Administration

Investigator ______________________ Phone ________________ Email ________________