



**CLINICAL & EPIDEMIOLOGICAL DATA FOR RABIES**

<b>Doctor's Information</b>				
Doctor's Name				
Hospital				
Contact No		E-mail		
<b>Patient Information</b>				
Patient's Name				
Address				
Hospital ID				
Sex	Male/ Female	Age		
Occupation				
Date of Illness Onset		OPD Visit Date		
Hospitalised	Yes/ No	Date Hospitalised		
Is/ Was patient in coma	Yes/ No	Date of coma onset		
Has the patient expired	Yes/ No	Date of Death		
Current differential diagnosis				
<b>Which of the following symptoms have been present? Tick all that apply</b>				
<b>Symptom</b>		<b>Duration</b>	<b>Symptom</b>	<b>Duration</b>
Fever			Aerophobia	
Malaise			Hydrophobia	
Headache			Localised weakness	
Nausea/ Vomit			Parasthesia	
Anxiety			Confusion	
Muscle Spasm			Agitation	
Dysphagia			Autonomic instability	
Anorexia			Hyperactivity	
Priapism			Hallucinations	
Seizures			Insomnia	
Ataxia			Hypersalivation	
SYMPTOMATIC DETAILS OF THE PATIENT ARE UNKNOWN (Please tick, if applicable) <input type="checkbox"/>				
<b>Animal Exposure</b>				
Any suspicious animal exposure		Yes/ No	Date of Exposure	
Species involved	<input type="checkbox"/> Dog	<input type="checkbox"/> Cat	<input type="checkbox"/> Other [Please Specify]:	
Exposure Type	<input type="checkbox"/> Bite	<input type="checkbox"/> Scratch	<input type="checkbox"/> Contact only	<input type="checkbox"/> Unknown
Any Post Exposure Prophylaxis [PEP] measures taken? If yes, give details:				
Additional Information (if any):				
<b>FOR OFFICE USE ONLY</b>				
SPECIMEN TYPE: _____		RECEIVED ON: _____		
SAMPLE ID: _____	RESULT: _____	DATE: _____		