



APPENDIX B: Rabies Exposure Report and Rabies Biologicals Request Form

If rabies biologicals are to be released from BCCDC during regular office hours, complete the following information and fax it to BCCDC Biologicals Desk at (604) 707-2581
Phone (604) 707-2582

CLIENT INFORMATION	
Last Name:	First Name:
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	PHN:
Present Weight: (kg)	Date of Birth: ____/____/____ (yyyy/mm/dd)
No. and Street Address:	
City/Town:	Phone #: H: () _____ W: () _____ Other: () _____
Postal Code:	
PHYSICIAN INFORMATION	
Last Name:	First Name:
No. and Street Address:	Phone: () _____
City/Town:	Postal Code:
ANIMAL INFORMATION	
Animal species: <input type="checkbox"/> Bat <input type="checkbox"/> Cat <input type="checkbox"/> Dog <input type="checkbox"/> Monkey ♦ <input type="checkbox"/> Other (describe) _____ <input type="checkbox"/> Unknown	
Animal type: <input type="checkbox"/> Household pet -indoor <input type="checkbox"/> Household pet -outdoor <input type="checkbox"/> Stray <input type="checkbox"/> Wild <input type="checkbox"/> Unknown	
Animal immunized against rabies? <input type="checkbox"/> Yes: ____/____/____ (yyyy/mm/dd) <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Animal behaviour at time of exposure:	
Observation period following exposure? <input type="checkbox"/> No <input type="checkbox"/> Yes, from: ____/____/____ to: ____/____/____ (yyyy/mm/dd) (yyyy/mm/dd)	
Observation location: _____	
Vet name: _____ Phone: () _____	
Brain sent for testing? <input type="checkbox"/> Yes <input type="checkbox"/> No Unknown	Date specimen shipped: ____/____/____ (yyyy/mm/dd)
Testing Result:	Date of test: ____/____/____ (yyyy/mm/dd)

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



BC Centre for Disease Control

Date of exposure: <u> </u> / <u> </u> / <u> </u> <i>yyyy mm dd</i>	Date of report: <u> </u> / <u> </u> / <u> </u> <i>yyyy mm dd</i>
Place of exposure: <input type="checkbox"/> BC <input type="checkbox"/> Other Canadian province/territory: _____ <input type="checkbox"/> Other country: _____	
Type of exposure: <input type="checkbox"/> 1-Bite <input type="checkbox"/> 2-Scratch <input type="checkbox"/> 3-Saliva <input type="checkbox"/> 4-Handling <input type="checkbox"/> 5-Bat Nearby	
Location of exposure: <input type="checkbox"/> 1-Head/Neck <input type="checkbox"/> 2-Torso <input type="checkbox"/> 3-Extremities <input type="checkbox"/> 4-Finger <input type="checkbox"/> 5-Mucosa <input type="checkbox"/> 6-Unknown <input type="checkbox"/> 7-Other, describe _____	
Any bleeding or breaks to skin? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Client previously immunized against rabies? <input type="checkbox"/> No <input type="checkbox"/> Yes, give date: <u> </u> / <u> </u> / <u> </u> (yyyy/mm/dd) Vaccine type: _____	
Reporting Health Service Delivery Area: _____ Client No. (to be filled in by HSDA): _____	
RPEP authorized by: _____ (print name of MHO or BCCDC Clinical person)	
Person who received authorization: _____ (print name)	
Biologicals to be shipped from a local depot: <input type="checkbox"/> Yes <input type="checkbox"/> No	
BIOLOGICALS TO BE SHIPPED TO	
Full Address:	Person Receiving:
Office Hours & Special Instructions:	Phone Number: () _____ After Hours Number: () _____ Expected Date/Time for Biologicals Arrival: <u> </u> / <u> </u> / <u> </u> (yyyy/mm/dd) <input type="checkbox"/> AM <input type="checkbox"/> PM
Submitted by: (please print) _____ Phone #: () _____	
BIOLOGICALS REQUESTED	
Rabies vaccine _____ vials (1 vial = 1 dose = 1ml)	
Rabies immune globulin _____ vials (1 vial = 2ml = 300 IU) Dose in ml: (20 IU x wt in kg) / 150 IU per ml = _____ml	