New Jersey Department of Health

REPORT OF RABIES POST-EXPOSURE TREATMENT

The treating health care provider shall complete and fax or mail this form to the Health Officer where the patient resides or relay the information below to the Health Officer via telephone. The Health Officer shall forward a copy of the completed form to the New Jersey Department of Health (NJDOH), Communicable Disease Service via fax or mail.

Name of Patient (Last, First, MI) _____ (Last / First / MI)

Date of Birth ____ / ____ / ____ (Mo / Da / Yr)

Age ____ (Years)

If Less Than 2 Years: ____ (Months)

Home Mailing Address of Patient

Sex
1 ☐ Male
2 ☐ Female
9 ☐ Unknown

Telephone Number ( )

Municipality of Residence

Munic. Code (Residence)

Municipality Where Exposure Occurred

Munic. Code (Exposure)

County Where Exposure Occurred

Hospital Where Treatment Initiated

Name of Treating Physician

Telephone Number

Type of Human Exposure *(Check All that apply)*
1☐ Multiple Bite
2☐ Single Bite
3☐ Scratch
4☐ Contamination of an abrasion, cut, open wound or mucous membranes with **SALIVA** or **CNS** fluid
5☐ Direct contact with bat
6☐ Other (Specify): _____
9☐ Unknown

Part of Body Exposed *(Check All that apply)*
1☐ Face/Neck/Head
2☐ Finger
3☐ Hand/Foot
4☐ Leg/Arm
5☐ Trunk
8☐ Other (Specify): _____

Rabid/Suspect Rabid Animal Involved in Exposure

01☐ Bat	06☐ Skunk	11☐ Groundhog	16☐ Ferret
02☐ Cat	07☐ Fox	12☐ Opossum	97☐ Other (Specify): _____
03☐ Dog	08☐ Rat	13☐ Muskrat	98☐ Unknown
04☐ Raccoon	09☐ Chipmunk	14☐ Mole	99☐ Blank
05☐ Squirrel	10☐ Rabbit	15☐ Horse	

Circumstances of Exposure *(Check All that apply)*
1☐ Completely unprovoked attack by rabid/suspect rabid animal
2☐ Attacked while entering area guarded by rabid/suspect rabid animal
3☐ Provoked attack (feeding/petting/touching/playing/picking up/treating/ nursing/examining/consoling rabid or suspect rabid animal)
4☐ Treating/nursing/examining/consoling pet/animal which had conflict with suspect rabid animal
5☐ Skinning/dressing rabid/suspect animal carcass
8☐ Other (Specify) _____
9☐ Unknown

Date of Exposure ____ / ____ / ____ (Mo / Da / Yr)

Date Treatment Begun ____ / ____ / ____ (Mo / Da / Yr)

Rabies Status of Exposing Animal
1☐ Tested positive
2☐ Tested negative
3☐ Under confinement
4☐ Not available
5☐ Unsatisfactory for testing
8☐ Other (Specify): _____

Type of Treatment
1☐ HRIG plus 4 doses of vaccine
2☐ 2 doses of vaccine (for prevaccinated individuals)
3☐ Incomplete course (treatment stopped after animal determined to be negative for rabies)
4☐ Incomplete course (treatment stopped by patient)
5☐ Treatment course initiated but patient lost to follow up
8☐ Other treatment (Specify): _____
9☐ Unknown

Name of Person Submitting Report

Title

Signature

Telephone Number

Name of Reporting Health Officer/Representative

Date Initially Reported

Name of Health Department

CDC-2
NOV 15

Distribution: The Health Officer retains a copy and forwards the form to the NJDOH, Communicable Disease Service.