



CONFIDENTIAL RABIES POST EXPOSURE PROPHYLAXIS (PEP)
REPORT FORM

(see reverse for instructions and routing procedures)

SECTION I: PATIENT INFORMATION

Social Security Number _____ Driver's License Number (optional) _____

Last Name _____ First Name _____ MI _____

Address _____

City _____ State _____ Zip _____ County _____

Phone Number: (____) _____ Date of Birth ____/____/____ Age _____

Gender:

- Male []
Female []
Unknown []

Race (check one):

- Am. Indian/Alaskan []
Asian/Pacific Islander []
Black []
White []
Other []
Unknown/not specified []

Ethnicity (check one):

- Hispanic []
Non-Hispanic []
Unknown []

SECTION II: BASIC CASE INFORMATION

Type of animal: _____

Date of the exposure: ____/____/____

Was animal tested for rabies? Yes [] No [] Unknown []

If Yes,

Date tested: ____/____/____

Result?

- Positive []
Negative []
Unsatisfactory []
Not done []

Why was animal tested?

- Wild []
Neurologic []
Injured []
Unknown []
Other []
L> (specify): _____

If No,

Why was animal not tested?

- Observed 10 days []
Quarantined []
Escaped []
Unknown []
Other []
L> (specify): _____

Was PEP recommended? Yes [] No [] Unknown []

Was PEP initiated? Yes [] No [] Unknown []

Animal was:

- Owned []
Stray []
Unknown []

Patient relationship to animal:

- Owner []
Occupational [] -> (specify): _____ Wild []
Other [] -> (specify): _____
Unknown []

Type of exposure (check one):

- Bite [] -> Where was the bite (anatomically)? _____
Scratch []
Other [] -> (specify): _____
Unknown []

Animal ever vaccinated against rabies?

- Yes [] ->
No []
Unknown []

If Vaccinated:

- Vaccinated by: Vet [] Owner [] Unknown []
Most recent vaccination: ____/____/____
Type of vaccination: _____
(e.g., 1st vaccine, 1-year, 3-year, unknown, etc.)

Was the attack provoked? Yes [] No [] Unknown []

SECTION III: OPTIONAL INFORMATION (FOR CHD USE ONLY)

Incident reported to Animal Control (AC)? Yes No No AC in County Unknown

Wound care information:

Patient washed wound: Yes No Unknown How long after exposure?: _____

Physician's wound care:

Patient saw physician on (date): ___/___/___

Washed/flushed wound Yes No Unknown

Gave tetanus Yes No Unknown

Gave antibiotics Yes No Unknown

Sutured wound Yes No Unknown

Other treatment (specify): _____

PEP Information:

Who was consulted for PEP recommendation?

County Health Department

State Health Office

If neither consulted, who recommended PEP?

Name: _____

Telephone : (_____) _____

Date PEP initiated: ___/___/___

Was patient previously vaccinated?

Yes No Unknown

If yes, date of vaccination: ___/___/___

Type of PEP:

HRIG + 4 vaccines

2 vaccines (previously vaccinated)

Continuing vaccinations → Begun in County _____ State _____

Other → Specify _____

PEP not given → Specify _____

PEP supplied by: DOH (State or CHD pharmacy) Private MD

PEP administered by: CHD ER Private MD

Form Completed by (print name)

County Health Department

Date

Purpose:

This form is to be completed for each person for whom PEP is recommended in Florida in order to help evaluate the Rabies Prevention and Control Program.

Routing Procedures:

After completing this form, please enter into Merlin.

Forms Retention Schedule:

This form is subject to the retention period specified in DOH Schedule 1, Item 2. Once data is entered into the Florida morbidity reporting system database, backed-up, and verified as entered, the electronic copy becomes the permanent record and the hard copy of the disease reporting form becomes a duplicate.

Instructions:

For instructions on how to complete this form, please see the following website:

<http://www.doh.state.fl.us/environment/medicine/rabies/rabies-index.html>