Government of India
NATIONAL CENTRE FOR DISEASE CONTROL
22-SHAMNATH MARG, DELHI-110054
Centre for Arboviral and Zoonotic Diseases

Proforma for a case of Hydrophobia/Acute Neurological Symptoms for Suspected Case of Rabies (Human)

Section 1 (To be filled by investigating officer)

Sr. no:	**Name:**	**Age:**	**Sex:**
Complete address:			
Place of death:	**Date of death:**	**PM no.:**	**PM date:**
FIR registered: Yes/No	**FIR details:**		
Date of custody of samples:	**Date of shipment of samples to: testing laboratory**		

Sign……
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Section 2 (To be filled by the treating doctor)

Date of admission **Date of animal bite:**

Animal species: **Dog/cat/Monkey/Mongoose/Others specify**

Type: Pet/Stray **Fate of animal: Alive/killed/unknown Bite:**

Provoked/Unprovoked/Not known

Outcome in other persons bitten: Alive/Dead/Not known

No. of other persons bitten by same animal within one week of the bite: Type of exposure:

1. **Licks on intact skin**
2. **Single or multiple bites with bleeding**
3. Licks on broken skin
4. **Minor scratches or abrasions without bleeding**
5. **Nibbling of uncovered skin**
6. **Contamination of mucous membrane with saliva**

Duration between bite and local treatment of wound : 0/1//2/3/4/5/6/7/more days

Local treatment taken before coming to anti rabies clinic : Yes/no/not known

If yes, tick whichever is applicable : Washed with water/washed with soap and water/any other specify
Who advised to come to anti rabies clinic : Self/Relative/Health worker/Neighbour/Friend/Previously treated Patient

Previous history:

P/H/O/ IMMUNIZATION :

a) **Immunized/**
b) **Incompletely immunized/Documents not available/**
c) **Unimmunized**

Sign……

Note: In case of no treating doctor, investigating officer to fill the details as far as possible.

Section 3 (To be filled by treating doctor)

Treatment given at anti rabies clinic	Details	Date
Wound washed in clinic	Yes/No	
Local instillation of ARS	Yes/No	
Wound suturing	Yes/No	
Antiseptic/cauterization	Yes/No	
Route of vaccine	ID/IM	
Any deviation from schedule		
Vaccine brand name and schedule details		
Vaccination document available	Yes/No	

Section 4 (To be filled by treating doctor)

Clinical symptoms	Details	Date of onset
Fever		
Local paraesthesia		
Breathlessness		
Paralysis		
Convulsions		
Hydrophobia		
Any other relevant details		
Treatment given		
Any other close contact of hydrophobia case		
Radiological investigations		

Cause of death:

Sign.....

Section 5 (To be filled by autopsy surgeon (preferably) and /or IO)

Findings on body	Details	Date
Bite marks/scratches/abrasions s/o animal bite or contact		
Any other relevant findings noted externally		

Section 6 (To be filled by IO)

Specimens of suspected case given to laboratory	Collection date	Transportation date	Name and ID No. of Authorized Messenger	Name of Police Station
Blood				
CSF				
Skin biopsy				
Saliva				
Corneal smear				
Brain				
Any other				

Signature of autopsy surgeon

Signature of IO