NATIONAL CENTRE FOR DISEASE CONTROL

(DIRECTORATE GENERAL OF HEALTH SERVICES)

22, SHAM NATH MARG, NEW DELHI – 110054

CENTRE FOR ARBOVIRAL AND ZOONOTIC DISEASES

WHO COLLABORATING CENTRE FOR RABIES EPIDEMIOLOGY

Proforma for a case of Hydrophobia/ Suspected Rabies (Human)

Name of Hospital:

Sr. No.: **Name:**

Age: **Sex:**

Complete Address

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 mucus membrane with saliva**

Duration between bite & 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 you to come to anti-rabies clinic **Self/Relative/Health worker/ Neighbour/ Friend/Previously treated patient**

Previous History :-

P/H/O IMMUNIZATION

(a) **Immunized**

(b) **Incomplete Immunized / No documents Available**

(c) **Unimmunized**

Treatment given at the anti-rabies clinic	Details	Date
Wound washed in the 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	

Clinical Symptoms	Details	Date of onset
Fever		
Local paraesthesia		
Breathlessness		
Paralysis		
Convulsions		
Hydrophobia		
Any other relevant details		
Treatment given		
Any other Close Contacts of hydrophobia case		

Specimens of suspected case given to laboratory	Collection Date	Transportation Date
Blood		
CSF		
Skin biopsy		
Saliva		
Corneal smear		
Brain		
Any other		

Radiological investigations (CT/MRI)

Death **Cause of Death :**
Date of Death :

Signature of Doctor

Date