

Form Approved
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Potential Rabies Exposure Assessment Form for Household, Co-worker and Patient Contacts

Public reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011)

Name of Interviewer (if applicable): _____

Interviewer email: _____

Interviewer phone: _____

Date of interview: _____

HD initiating this questionnaire

Dept of Health

Other _____

Respondent Information

Name: _____

Address: _____

Home Phone: _____

Work Phone: _____

Municipality: _____

Occupation: _____

Employer: _____

DOB: _____

Sex: M F

Age: _____ yrs

If a minor, name of parent or guardian: _____

If different than above:

Address: _____

Home Phone: _____

Work Phone: _____

Relationship to patient: (check all that apply)

Friend Housemate

Coworker Relative

Other, please describe: _____

1. Did you had any type of contact with the patient since 11/9/15?

Yes No

If no, thank you for participating in the survey. No additional follow up is needed.

2. What dates since 11/9/15 did you have contact with the patient?

3. Did you ever share food or drinks with the patient in such a way that fresh saliva from this patient may have come into contact with your mouth since 11/9/15? (e.g., sharing a

drink where both of you were drinking out of the same bottle/glass/can at the same time, sharing the same utensil while eating at the same time or sharing a sandwich that the patient was also eating such that your mouth may have been exposed to fresh saliva from the patient)

Yes No Unsure

4. Did you share a cigarette with the patient since 11/9/15?

Yes No Unsure

5. Since 11/9/15, did you share a toothbrush, floss, or other oral hygiene product with the patient?

Yes No Unsure

6. Did you kiss the patient on the mouth since 11/9/15?

Yes No Unsure

7. Did you have direct, barehanded contact with this patient's saliva since 11/9/15?

Yes No Unsure

If no, go to question #9

8. When you had direct, barehanded contact with the patient's saliva, did the saliva have contact with any skin that was not intact? (e.g., a fresh, open wound or cut that was not scabbed over)

Yes No Unsure

9. Did you ever have direct, barehanded contact with the patient's tears?

Yes No Unsure

If no, go to question #11

10. When you had direct, barehanded contact with the patient's tears, did this fluid have contact with any skin that was not intact? (e.g., a fresh, open wound or cut that was not scabbed over)

Yes No Unsure

11. Were you bitten by this patient at any time since 11/9/15?

Yes No Unsure

If no, go to question #13

12. Did the bite break the skin?

Yes No

13. Have you ever been immunized against rabies (before or after a potential exposure)?

No Yes (specify date/circumstance) _____

Which vaccine? _____

Recent titer drawn? Date_____ Results?_____

A Puerto Rico public health representative will be in touch with you within a few days to discuss whether or not you need rabies postexposure prophylaxis. In the meantime, if you have any questions, please call _____.

Interviewer:

After completion of assessment, please email to [] or FAX to [].