Form Approved

OMB No. 0920-1011

Exp Date 3/31/17

**HEALTHCARE WORKER**

**RABIES EXPOSURE QUESTIONNAIRE**

Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone # (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_

 Work Phone# (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Age \_\_\_\_\_\_\_\_\_\_\_\_\_ (years)
2. Sex: M F
3. In which department do you work? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. What is your job title? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe your job: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Did you have any physical contact with the patient, his bodily secretions, laboratory specimens, or tissue?

No \_\_\_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_\_\_\_

If NO, go to # 11

1. About how much time did you spend with the patient? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (hours)
2. Were you bitten by the patient? No \_\_\_\_\_\_ Yes \_\_\_\_\_
3. Were you kissed by the patient? No \_\_\_\_\_\_ Yes \_\_\_\_\_
4. Were you in contact with any of the patient’s fluids or secretions listed below? (Check each selection that applies)

**If YES, was it on:**

Bare Skin Gloves, Etc.

* 1. Saliva No \_\_\_ Yes \_\_\_ \_\_\_\_\_ \_\_\_\_\_
	2. Respiratory secretions No \_\_\_ Yes \_\_\_ \_\_\_\_\_ \_\_\_\_\_
	3. Cerebrospinal fluid No \_\_\_ Yes \_\_\_ \_\_\_\_\_ \_\_\_\_\_
	4. Tears No \_\_\_ Yes \_\_\_ \_\_\_\_\_ \_\_\_\_\_

1. Did you have a fresh wound, cut or other break in skin that may have been in contact with the patient’s oral secretions?

No \_\_\_\_\_ Yes\_\_\_\_\_

If YES: Location of wound/cut break \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which secretions?

* 1. Saliva \_\_\_\_\_
	2. Respiratory secretions \_\_\_\_\_
	3. Cerebrospinal fluid \_\_\_\_\_
	4. Tears \_\_\_\_\_
1. Did any of the patient’s oral secretions come in contact with your eyes, mouth, or nose (mucous membranes)?

No \_\_\_\_\_ Yes\_\_\_\_\_

If YES: Describe secretions, mucous membranes & circumstances.

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1. Did you participate in any procedure performed on the patient? (Include intubation, lumbar puncture, nasogastric tube insertion)

No \_\_\_\_\_ Yes\_\_\_\_\_

If YES: Which procedure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What personal protective equipment did you use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you have any breaks in your gloves?

No \_\_\_\_\_ Yes\_\_\_\_\_

1. In your opinion, what was your most significant exposure? What was the exposure you are most concerned about?

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1. Have you previously been immunized against rabies?

No \_\_\_\_\_ Yes\_\_\_\_\_

If YES: When? (Month/Year) \_\_\_\_\_\_/\_\_\_\_\_\_

Why were you immunized? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which vaccine? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_