

## **HEALTHCARE WORKER RABIES EXPOSURE QUESTIONNAIRE**

Public reporting burden of this collection of information is estimated to average 15 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)



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

Which secretions?

- 1. Saliva \_\_\_\_\_
- 2. Respiratory secretions \_\_\_\_\_
- 3. Cerebrospinal fluid \_\_\_\_\_
- 4. Tears \_\_\_\_\_

15. 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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16. 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?

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Did you have any breaks in your gloves?

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

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

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18. Have you previously been immunized against rabies?

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

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

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

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