

FORM 1. Primary patient data upon visit of patient to clinic

Clinic: (Candijay/Carmen/Jagna/Loon/Tagbilaran/Talibon/Ubay)

VICTIM PROFILE

Name _____
Age _____ years
_____ months
Sex Male Female
Status of the victim Alive Dead, date of death(MM/DD/YYYY) _____

Address of the victim
House name/number and street _____
Sitio _____
Barangay _____
Municipality/city _____

Telephone Number _____ **VITAL INFORMATION**
Bite date (MM/DD/YYYY) _____ **VITAL INFORMATION**

Date Type Date bitten Date of first treatment
Activity Date Estimate Accurate +/- 1 day +/- 1 week
 +/- 1 month +/- 1 year

Location where biting incident happened Household Neighborhood
 Others, specify _____

Time of Bite _____
Site of Bite (body part/s) _____
Number of Wounds _____ Brief description of wound type _____

Bite provoked? Yes No
Description of the circumstance _____

Nature of Bite Minor Moderate Severe
Bite Category (WHO Classification) I II III

Treatment Received
Wound washed? No
 Water
 With soap
 Antiseptic
 Alcohol
 Iodine
 Others (specify) _____

Time interval between bite and wound treatment _____ minutes/hours/days
Application of local irritants (e.g. bleach, gasoline) Yes, specify _____ No

Wound dressed/bandaged? Yes No
Wound sutured? Yes No
If traditional method, specify Tandok Stone Horn Ritual
 Others, specify _____

Check if vaccine administered
Day 0 Date (MM/DD/YYYY) _____ **Patient follow up starts 14 days after this date**
Day 3 Date (MM/DD/YYYY) _____ **Update Wise-Monkey entry of patient**
Day 7 Date (MM/DD/YYYY) _____ **Update Wise-Monkey entry of patient**
Day 28/30 Date (MM/DD/YYYY) _____ **Update Wise-Monkey entry of patient**

Treatment Type IM ID
Antitetanus Yes No
Immunoglobulin Type ERIG HRIG No
Dose amount of immunoglobulin _____ ml or _____ IU

If patient is dead, signs observed prior to death of the victim _____ **PROMPT FOR INVESTIGATION**
_____ **ALL DEATHS SHOULD BE INVESTIGATED IN THE FIELD**

IF PATIENT DID NOT GO FOR OR DID NOT CONTINUE TREATMENT:
Reason/s why patient did not get treatment: _____ **ASK ABOUT STATUS OF BITING ANIMAL. IF CASE IS**
_____ **SUSPICIOUS, INVESTIGATE AND FOLLOW UP ON**
_____ **PATIENT FOR TREATMENT**

FORM 2. Patient follow up (14 days after Day 0 of PEP)

ID of bite victim _____ *ID assigned by Wise-Monkey*
Name of the victim _____
Status of the victim Alive Dead, date of death(MM/DD/YYYY) _____

Species of biting animal _____
Breed of biting animal _____
Sex of biting animal Male Female
Age of biting animal
____ years
____ months

If owned: *If not owned skip questions about the owner*
Name of owner _____
Address of owner
House name/number and street _____
Sitio _____
Barangay _____
Municipality/city _____

Pet Management Pet Confined Free/Stray Wild
Was biting animal available for 10-14 day observation Yes No

Rabies vaccination status of dog, if known
Unvaccinated
Vaccinated within the last 12 months
Vaccinated more than 12 months ago

Status of Animal
Healthy *IF HEALTHY, END HERE. NO NEED FOR FIELD INVESTIGATION*
Sick *PROMPT FOR INVESTIGATION*
Died *PROMPT FOR INVESTIGATION. MUST DO OUTBREAK INVESTIGATION*
Killed *PROMPT FOR INVESTIGATION*
Not traceable *PROMPT FOR INVESTIGATION. IF DOG NOT FOUND, CONTINUE PEP OF PATIENT*
Unknown *PROMPT FOR INVESTIGATION*

FORM 3. Animal Bite Investigation Form - to be completed in the field (only when field investigation is necessary)

Investigated by: _____

Date of investigation: _____

ID of bite victim: _____ *ID assigned by Wise-Monkey*

ANIMAL PROFILE

If owned: _____ *If not owned skip questions about the owner*

Name of owner _____

Address of owner

House name/number and street _____

Sitio _____

Barangay _____

Municipality/city _____

Telephone number of owner _____

Species _____

Breed _____

Sex Male Female

Age _____ years
_____ months

Pet Management Pet Confined
 Free/Stray Wild

Status of Animal Sick Died Killed
 Not traceable Unknown

Cause of Death Euthanasia Accident Found dead
 Illness Others, specify _____

Date of Death _____

Time of Death _____

IF SICK, duration of illness *Skip question if no one can answer (because owner is unknown)*

From (MM/DD/YYYY) _____

To (MM/DD/YYYY) _____

Rabies vaccination status of dog, if known Unvaccinated Vaccinated within the last 12 months *Skip question if no one can answer (because owner is unknown)*
 Vaccinated more than 12 months ago

Vaccination History *Skip question if no one can answer (because owner is unknown)*

Rabies Date (MM/DD/YYYY) _____

Other _____ Date (MM/DD/YYYY) _____

Availability of biting animal for 10-14 day observation Yes No

Classification Proven rabid Suspect rabid Healthy *To be completed after lab test*

Postmortem/lab test report Yes No

Result of postmortem/lab test report Positive Negative

Number of dogs owned _____ *Skip question if no one can answer (because owner is unknown)*

Estimated number of dogs in the community _____

| Behavioral Changes | Check | Other Signs of Illness | Check |
|----------------------------|--------------------------|------------------------|--------------------------|
| None | <input type="checkbox"/> | None | <input type="checkbox"/> |
| Restlessness | <input type="checkbox"/> | Diarrhea | <input type="checkbox"/> |
| Apprehensive watchful look | <input type="checkbox"/> | Vomiting | <input type="checkbox"/> |
| Unprovoked aggressiveness | <input type="checkbox"/> | Inappetence | <input type="checkbox"/> |
| Aimless running | <input type="checkbox"/> | Jaundice | <input type="checkbox"/> |
| Deprived appetite | <input type="checkbox"/> | Skin lesions | <input type="checkbox"/> |
| Drooling saliva | <input type="checkbox"/> | Lethargy | <input type="checkbox"/> |
| Paralysis: | <input type="checkbox"/> | Nasal/Ocular discharge | <input type="checkbox"/> |
| Hindleg | <input type="checkbox"/> | Convulsion/Seizures | <input type="checkbox"/> |
| Jaw/Tongue | <input type="checkbox"/> | | |

If these were observed even in an animal of unknown origin, COMPLETE THIS INFORMATION

Number of other persons bitten by the same animal (during the same week) _____ *Record their names* _____

If no records for these victims, carry out patient follow up survey in field

Did biting animal bite other animals? Yes, date (MM/DD/YYYY) _____ No

If Yes, record names of other animal owners: _____ *Carry out field investigation with the newly identified owner of other bitten animals*

Was the animal bitten by a suspect rabid animal? Yes, date (MM/DD/YYYY) _____ No

If yes, record owner of biting animal, if known: _____ *If yes, carry out field investigation with the newly identified owner*