

**REQUEST FORM FOR RABIES TESTING (HUMAN CLINICAL SPECIMENS)**

Patient Information			
Name of the patient:			
Age: ___ Years ___ Months	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/> Others <input type="checkbox"/>		Hospital IP/OP No.:
Name of spouse/parent/guardian:			
Address:			
Village/Town:	Taluka :	District:	State:
Referring Hospital:		Department:	
Attending physician: Dr.		Contact No.:	Email:
Date of onset of illness: ___/___/20___	Date of hospital admission: ___/___/20___	If expired, date of death: ___/___/20___	
Provisional diagnosis:			
Purpose of testing	Ante-mortem testing for rabies <input type="checkbox"/>	Post-mortem testing for rabies <input type="checkbox"/>	
Exposure History (Please tick the relevant responses)			
Known history of exposure to a suspected/confirmed rabid animal: Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>			
If yes, date of exposure: ___/___/20___ Was this a repeat exposure? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>			
Type of animal involved: Domestic/pet <input type="checkbox"/> Stray <input type="checkbox"/> Wild <input type="checkbox"/>		Type of bite: Provoked <input type="checkbox"/> Unprovoked <input type="checkbox"/> Unknown <input type="checkbox"/>	
Species of animal involved	Dog <input type="checkbox"/> Cat <input type="checkbox"/> Fox <input type="checkbox"/> Jackal <input type="checkbox"/> Cattle <input type="checkbox"/> Sheep <input type="checkbox"/> Goat <input type="checkbox"/> Monkey <input type="checkbox"/>		
	Mongoose <input type="checkbox"/> Bat <input type="checkbox"/> Others (Specify):		
Rabies vaccination status of the animal (if domestic/pet)	Vaccinated <input type="checkbox"/> Unvaccinated <input type="checkbox"/> Unknown <input type="checkbox"/>		
Body part affected	Head and neck <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Hands <input type="checkbox"/> Fingers <input type="checkbox"/> Thighs <input type="checkbox"/> Legs <input type="checkbox"/>		
	Toes <input type="checkbox"/> Genitals <input type="checkbox"/> Others (Specify):		
Category of Exposure	Category I <input type="checkbox"/>	Category II <input type="checkbox"/>	Category III <input type="checkbox"/>

Post-Exposure Rabies Prophylaxis Received (Please tick the relevant responses)					
Local wound management	Immediate washing of exposed area with soap and water Done <input type="checkbox"/> Not done <input type="checkbox"/> Unknown <input type="checkbox"/>				
	Application of antiseptic to the exposed area after washing Done <input type="checkbox"/> Not done <input type="checkbox"/> Unknown <input type="checkbox"/>				
	History of application of herbal extracts/turmeric/ash etc. to the area Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>				
	Wound suturing Done <input type="checkbox"/> Not done <input type="checkbox"/> Unknown <input type="checkbox"/>				
Rabies vaccination	Receipt of rabies vaccine immediately after exposure Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>				
	Delay, if any, till administration of 1 <sup>st</sup> dose of rabies vaccine:				
	History of previous pre-exposure/post-exposure prophylaxis for rabies:				
	Details of rabies vaccine received				
	Type of vaccine:	No. of doses received:	Route: IM <input type="checkbox"/> ID <input type="checkbox"/>		
	Date	1 <sup>st</sup> Dose:	2 <sup>nd</sup> Dose:	3 <sup>rd</sup> Dose:	4 <sup>th</sup> Dose: 5 <sup>th</sup> Dose:
Missed dose(s), if any:					
Administration of rabies immunoglobulin (RIG)/rabies monoclonal globulin (RMG)	Infiltration of all wounds with RIG/RMG Done <input type="checkbox"/> Not done <input type="checkbox"/> Unknown <input type="checkbox"/>				
	Delay, if any, till administration of RIG/RMG (from the time of exposure) Less than 24 hours <input type="checkbox"/> 25-72 hours <input type="checkbox"/> 72 hours-7 days <input type="checkbox"/> More than 7 days <input type="checkbox"/>				
	Type of preparation received	Equine RIG <input type="checkbox"/> Human RIG <input type="checkbox"/> Rabies Monoclonal Globulin <input type="checkbox"/>			
	Mode of administration	Infiltration into wound(s) <input type="checkbox"/> Intramuscular injection <input type="checkbox"/> Both <input type="checkbox"/>			

Brief Clinical History	

Does the patient meet the case definitions for rabies? (Please tick the relevant category)	Suspected case of rabies <input type="checkbox"/>		Probable case of rabies <input type="checkbox"/>	
	Clinical presentation	Encephalitic <input type="checkbox"/>	Paralytic <input type="checkbox"/>	Atypical <input type="checkbox"/>

Laboratory and Imaging Findings (Please attach relevant copies)			
CSF	Protein: ___ mg/dL	Glucose: ___ mg/dL	
	Total cell count ___ cells/mm <sup>3</sup>	Differential count:	
CT Scan	Done <input type="checkbox"/>	Not done <input type="checkbox"/>	Date performed: ___/___/20___
	Summary findings:		
MRI Scan	Done <input type="checkbox"/>	Not done <input type="checkbox"/>	Date performed: ___/___/20___
	Summary findings:		
Findings from routine laboratory investigations			

Sl. No.	Type of specimen (Please tick the relevant option)	Ante-mortem/post-mortem	Date of collection
1	Salivary impression <input type="checkbox"/>		
2	Corneal impression <input type="checkbox"/>		
3	Brain tissue <input type="checkbox"/>		
4	Others (Specify) <input type="checkbox"/>		

For Laboratory Use Only			
Date of receipt of samples: ___/___/20___		Time of receipt: ___:___ HRS	Received by: _____
Quality Control Check	Pass <input type="checkbox"/>	Fail <input type="checkbox"/>	If failed, reason: _____
Date of testing: ___/___/20___		Tests done:	
Date of issuing test report: ___/___/20___			

### Consent Form (For Patients Aged 18 years and above)

I, **Mr./Mrs./Kum.** \_\_\_\_\_, aged \_\_\_years \_\_\_months hereby give my full consent for collection of clinical samples of self/the patient (*strike off whichever is not relevant*) named **Mr./Mrs./Kum.** \_\_\_\_\_ aged \_\_\_years\_\_\_months, for laboratory testing for rabies at Smt. NHL Municipal Medical College, Ahmedabad. I hereby **give / do not give** (*strike off whichever is not relevant*) my full consent to the Smt. NHL Municipal Medical College, Ahmedabad, Gujarat, India, to preserve the remainder of the clinical samples for additional testing for other probable causes of neurological infections and to use them for future research related to public health, virology or clinical medicine, maintaining full anonymity and confidentiality of my identity, and with due approval from competent authorities.

\_\_\_\_\_   
Date

\_\_\_\_\_   
Name of the person signing the consent   
and relationship with the patient

\_\_\_\_\_   
Signature /thumb impression of the person   
signing the consent

\_\_\_\_\_   
Signature of a witness

### Assent Form (For Patients Aged 12-17 years)

I, **Master/Miss** \_\_\_\_\_, aged \_\_\_years \_\_\_months hereby give my full Consent for collection of my clinical samples for rabies testing at Smt. NHL Municipal Medical College, Ahmedabad. I hereby **give / do not give** (*strike off whichever is not relevant*) my full consent to Smt. NHL Municipal Medical College, Ahmedabad, Gujarat, India, to store the leftover samples for further testing for other disease-causing agents and to use them in health-related research in future.

\_\_\_\_\_   
Date

\_\_\_\_\_   
Name of the patient

\_\_\_\_\_   
Signature /thumb impression of the patient

\_\_\_\_\_   
Signature of a witness

### Parental/Guardian Consent Form (For Patients Aged 0-12 years)

I, **Mr./Mrs./Kum.** \_\_\_\_\_, aged \_\_\_years \_\_\_months hereby give my full consent for collection of clinical samples of the patient named \_\_\_\_\_ aged \_\_\_years\_\_\_months, for laboratory testing for rabies at Smt. NHL Municipal Medical College, Ahmedabad. I hereby **give / do not give** (*strike off whichever is not relevant*) my full consent to the Smt. NHL Municipal Medical College, Ahmedabad, Gujarat, India, to preserve the remainder of the clinical samples for additional testing for other probable causes of neurological infections and to use them for future research related to public health, virology or clinical medicine, maintaining full anonymity and confidentiality of my identity, and with due approval from competent authorities.

\_\_\_\_\_   
Date

\_\_\_\_\_   
Name of the parent/guardian signing the consent   
and relationship with the patient

\_\_\_\_\_   
Signature /thumb impression of the parent/guardian   
signing the consent

\_\_\_\_\_   
Signature of a witness