

REPORT OF SUSPECTED RABIES EXPOSURE

Health

STEP 1 - INITIAL INTAKE: TO BE COMPLETED **BY THE FIRST HEALTH CARE PROVIDER (HCP) TO SEE PATIENT** AND **FAXED IMMEDIATELY TO THE *APPROPRIATE REGIONAL PUBLIC HEALTH OFFICE** (CONTACT DETAILS ON PAGE 3). **FIRST HCP CALLS THE MEDICAL OFFICER OF HEALTH (MOH) IMMEDIATELY AT 204-788-8666 IF CASE IS HIGH RISK (e.g. INVOLVES A WILD ANIMAL - SEE APPENDIX D IN PROTOCOL FOR RISK STRATIFICATION).** CONTACT THE *APPROPRIATE REGIONAL PUBLIC HEALTH NURSE IMMEDIATELY IF UNSURE OF WHAT TO DO. *Appropriate = where the exposed person lives/will be living during the exposure follow-up period.

REPORTED BY	TELEPHONE / ALTERNATE TELEPHONE	RELATIONSHIP TO EXPOSED INDIVIDUAL	MANITOBA HEALTH ONLY	
REPORT RECEIVED BY / TELEPHONE	DATE (YYYY/MM/DD)	24-HOUR TIME	MH ID _____	CFIA ID _____

To assist with the MOH's determination of risk, please also complete the risk assessment fields (highlighted in yellow in Step 2's box below)

EXPOSED INDIVIDUAL'S INFORMATION					PHIN:	
LAST NAME		FIRST NAME		DATE OF BIRTH (YYYY/MM/DD)	SEX	WEIGHT (KG)
*STREET	*CITY	*PROVINCE	*HEALTH REGION	*POSTAL CODE	TELEPHONE	ALTERNATE TELEPHONE
ANIMAL OWNER'S NAME AND CONTACT INFORMATION						
LAST NAME		FIRST NAME		TELEPHONE / ALTERNATE TELEPHONE		
STREET				CITY		
PROVINCE		POSTAL CODE		HEALTH REGION		
**TYPE OF ANIMAL				DESCRIPTION OF ANIMAL		
ALL APPLICABLE PARTIES ADVISED NOT TO DESTROY ANIMAL AND OBSERVE FOR 10 DAYS YES NO				DATE OF EXPOSURE (YYYY/MM/DD)		

STEP 2: HEALTH CARE PROVIDER OR PUBLIC HEALTH NURSE TO COMPLETE AS MUCH AS POSSIBLE

To assist with the MOH's determination of risk, please also complete the risk assessment fields (highlighted in yellow in Step 2's box below)

EXPOSURE INFORMATION							
BEHAVIOUR AND CONDITION OF ANIMAL AT TIME OF EXPOSURE				GEOGRAPHIC LOCATION WHERE EXPOSURE OCCURRED			
ANATOMICAL SITE EXPOSED HEAD/NECK TORSO LIMB OTHER				TYPE OF EXPOSURE BITE SCRATCH BAT OTHER OPEN WOUND MUCOUS MEMBRANE			
IS THIS A DOMESTIC ANIMAL? YES NO UNKNOWN		STRAY OR WILD ANIMAL YES NO UNKNOWN		WERE THERE OTHER DOMESTIC ANIMALS EXPOSED? YES NO UNKNOWN		ANIMAL UNDER OBSERVATION YES NO UNKNOWN EUTHANIZED	
WAS THIS A PROVOKED ATTACK YES NO UNKNOWN		SAMPLE COLLECTION REQUIRED? YES NO		IF DOMESTIC ANIMAL, DATE OF LAST RABIES IMMUNIZATION (YYYY/MM/DD) VET CLINIC			
EXPOSED INDIVIDUALS IMMUNIZATION HISTORY						DATE OF LAST TETANUS IMMUNIZATION (YYYY/MM/DD)	
RABIES IMMUNIZATION WITHIN PAST 2 YEARS NUMBER OF DOSES: DATE(S) (YYYY/MM/DD)						IMMUNOCOMPETENT YES NO UNKNOWN	

**See Section 8.3 in protocol for a list of which animal exposures are rarely reportable.

OTHER INFORMATION – ANY PERTINENT INFORMATION NEEDED FOR CASE MANAGEMENT
(e.g. primary care provider information, wound management, prophylaxis recommendations, additional animal information, additional owner information, etc.)

FAX IMMEDIATELY TO REGIONAL PUBLIC HEALTH OFFICE (CONTACT DETAILS ON PAGE 3)

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STEP3: PUBLIC HEALTH PRACTITIONER TO COMPLETE FORM AND FAX TO 204-948-2190 (MRC)

ACTIONS TAKEN	
ANIMAL NO FURTHER ACTION OBSERVE FOR 10 DAYS UNTIL (YYYY/MM/DD) _____ LOOK FOR ANIMAL UNTIL (YYYY/MM/DD) _____ IF FOUND IF NOT FOUND SPECIMEN SENT FOR TESTING YES NO	EXPOSED RABIES IMMUNE GLOBULIN (Rabig) RECOMMENDED YES NO RABIES VACCINE RECOMMENDED YES NO

OUTCOME	
ANIMAL ANIMAL WELL AT 10 DAYS <input type="checkbox"/> ANIMAL NOT FOUND <input type="checkbox"/> RABIES REPORT POSITIVE RABIES REPORT NEGATIVE	EXPOSED RABIES IMMUNE GLOBULIN COMPLETED YES NO DATE(YYYY/MM/DD) _____ NUMBER OF RIG VIALS USED _____ mls NUMBER OF VACCINE DOSES GIVEN _____ DATES GIVEN (YYYY/MM/DD) 1) _____ 2) _____ 3) _____ 4) _____ 5) _____ REASON FOR PROPHYLAXIS INCOMPLETE

RABIES IMMUNE GLOBULIN DOSAGE			
Circle volume and number of vials required			
KG	LB	VOLUME (ml) (300I.U./ml)	NO . OF 1ml VIALS
3	7	0.2	1
4	9	0.27	1
5	11	0.33	1
10	22	0.67	1
15	33	1.0	1
20	44	1.3	2
25	55	1.7	2
30	66	2.0	2
35	77	2.3	3
40	88	2.7	3
45	100	3.0	3
50	111	3.3	4
55	121	3.7	4
60	132	4.0	4
65	143	4.3	5
70	155	4.7	5
75	165	5.0	5
80	176	5.3	6
85	187	5.7	6
90	198	6.0	6
100	220	6.7	7
110	242	7.3	8
120	264	8	8

NAME OF MEDICAL OFFICER OF HEALTH DATE (YYYY/MM/DD) _____
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a) To calculate volume in ml= kg * 0.067 b) To calculate number of vials = ml/1 (Round all decimals up)
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***HyperRab Format 1 x 2mL of 150 IU/mL injectable solution has transitioned to HyperRab Format 1 x 1mL of 300 IU/mL, injectable solution.**

REGIONAL CONTACT INFORMATION:

WINNIPEG REGIONAL HEALTH AUTHORITY (WR)

CD Intake – Winnipeg WRHARabies@wrha.mb.ca Tel: 204-940-2081 Fax: 204-940-2690

CD Intake – Churchill rcranford@wrha-ch.ca

Tel: 204-675-8327 Fax: 204-675-2445

After hours and W/E Fax: 204-675-2312

INTERLAKE-EASTERN REGIONAL HEALTH AUTHORITY (IE)

CD Coordinator rabiesreporting@ierha.ca Tel: 204-467-4757 Fax: 204-467-4765

SOUTHERN HEALTH – SANTE SUD (SH)

CD Coordinator rabies@southernhealth.ca Tel: 204-428-2772 Fax: 204-428-2734

PRAIRIE MOUNTAIN HEALTH (PMH)

PH Manager communicabledisease@pmh-mb.ca Tel: 204-578-2500 Fax: 204-759-4033

NORTHERN REGIONAL HEALTH AUTHORITY (NR)

PH Manager rmacdonald2@nrha.ca Tel: 204-778-1538 Fax: 204-778-1741

FIRST NATIONS INUIT HEALTH BRANCH

mbphu@sac-isc.gc.ca

Public Health Unit

Tel: 431-336-6487 Fax: 204-984-7271

Nurse Manager On Call (after hours)

Tel: 204-918-5428

MANITOBA PUBLIC HEALTH

Rabies Coordinator rabies@gov.mb.ca

Tel: 204-788-8666 Fax: 204-948-2190