

# **Rabies Outreach Program: Animal Exposure Questionnaire**

**Approved for Public Release, Distribution Unlimited  
Communicable Disease Reports (Animals): 40-400Z1**

**September 2011**



## Rabies Outreach Program: Animal Exposure Questionnaire

This questionnaire should be completed by individuals who had potential exposure to rabies during a deployment since 1 March 2010. Medical providers will use this information to assess potential risk for rabies and to determine any treatment that may be indicated.

Today's Date \_\_\_\_\_  
MM/DD/YYYY

### SECTION-1: Personal Information

Last Name \_\_\_\_\_

First Name \_\_\_\_\_

Middle Name \_\_\_\_\_

SSN \_\_\_\_\_ Rank \_\_\_\_\_ DOB \_\_\_\_\_

Sex  Male  Female

#### Service

Army  Navy  Air Force  Marines  Coast Guard

Civilian  Contractor  Other (specify) \_\_\_\_\_

MOS/AFSC \_\_\_\_\_ Unit \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Email \_\_\_\_\_

Cell phone \_\_\_\_\_

Work phone \_\_\_\_\_

Other phone \_\_\_\_\_

How many separate animal exposures—bites, scratches, broken skin that may have been contaminated with animal saliva, or exposures of animal saliva to mucous membranes (eyes, mouth, nose)—have you had since 1 March 2010? *(Do not include those from vaccinated pets in CONUS)*

One  Two  Three  Other (specify) \_\_\_\_\_

**NOTE: Complete a new copy of Section-2 below for EACH exposure incident**

Name (Last, First) \_\_\_\_\_ SSN \_\_\_\_\_

Exposure number described on this copy of the form:

Exposure \_\_\_\_ of \_\_\_\_ total exposures since 1 March 2010

## Section-2: Exposure Information

*Complete a new copy of this section for EACH exposure incident since 1 Mar 2010*

Date of exposure \_\_\_\_\_  
MM/DD/YYYY

### Country where exposure occurred

Afghanistan     Iraq     Other (specify) \_\_\_\_\_

### Type of exposure (check all that apply)

- Bite  
 Scratch  
 Animal saliva in eye, nose, mouth or broken skin  
 Other (specify) \_\_\_\_\_

### Type of animal

Dog     Cat     Other (specify) \_\_\_\_\_

US/NATO Military Working Dog     Yes     No     Unknown

Adopted local animal (mascot, pet)     Yes     No     Unknown

Feral (Stray) Animal     Yes     No     Unknown

Other (specify) \_\_\_\_\_

### Vaccination status of animal

Current (US/NATO Military Working Dog)     Unknown

### Location of the exposure

On the FOB     On patrol     Other (specify) \_\_\_\_\_

### Describe how the exposure happened

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Name (Last, First) \_\_\_\_\_ SSN \_\_\_\_\_

Exposure number described on this copy of the form:

Exposure \_\_\_\_ of \_\_\_\_ total exposures since 1 March 2010

**What was done to the animal after the exposure? (check all that apply)**

- Animal was confined and observed for at least 10 days
- Animal was euthanized (put to sleep)
- Nothing
- Don't know
- Other (specify) \_\_\_\_\_

**If the animal was put to sleep, were parts of it sent for rabies testing?**

- Yes
- No
- Don't know

**Did the same animal appear perfectly healthy 10 or more days after the exposure?**

- Yes, I saw the same animal and it appeared healthy on or after day 10 (alert, not overly aggressive, walking normally, not drooling)
- I did not see the animal 10 or more days after the exposure
- Don't know
- Other (specify) \_\_\_\_\_

**Result of rabies test on the animal (if done):**

- Positive
- Negative
- Don't know

**Who told you the rabies test results?** \_\_\_\_\_

**Describe the injury/injuries (bite, scratch) and the location(s) on your body**

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**Did the bite or scratch break the skin?**

- Yes
- No
- Don't Know
- N/A

**Did you bleed from the bite or scratch?**

- Yes
- No
- Don't Know
- N/A

**Did you see a medical care provider for this exposure?**

- Yes
- No
- Don't Know
- N/A

**If not, why not?** \_\_\_\_\_

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Name (Last, First) \_\_\_\_\_ SSN \_\_\_\_\_

Exposure number described on this copy of the form:

Exposure \_\_\_\_ of \_\_\_\_ total exposures since 1 March 2010

**If you received medical care, answer the following:**

**Location where treatment was provided** (name of FOB, etc)? \_\_\_\_\_

**Type of medical provider?**

Physician    PA    Medic    Don't Know    Other \_\_\_\_\_

**Name of provider** \_\_\_\_\_ **Unit of provider** \_\_\_\_\_

**Date of treatment** \_\_\_\_\_  
MM/DD/YYYY

**Did you ever have a previous rabies vaccination series (at least three shots) before this exposure occurred?**

Yes    No    Don't Know

**Did the provider say you needed a rabies vaccination after this exposure?**

Yes    No    Don't Know

**Treatment already provided (check all that apply)**

<input type="checkbox"/> None	<input type="checkbox"/> Rabies vaccine dose #1 (on Day-0)
<input type="checkbox"/> Wound cleaning with soap and water	<input type="checkbox"/> Rabies vaccine dose #2 (on Day-3)
<input type="checkbox"/> Tetanus shot	<input type="checkbox"/> Rabies vaccine dose #3 (on Day-7)
<input type="checkbox"/> Antibiotics	<input type="checkbox"/> Rabies vaccine dose #4 (on Day-14)
<input type="checkbox"/> Rabies Immunoglobulin (RIG) (on Day 0-7)	<input type="checkbox"/> Rabies vaccine dose #5 (on Day-28)
<input type="checkbox"/> Other (specify) _____	

**Were you taking malaria pills when you received any vaccine doses?**

Yes    No    Don't Know

**Do you have a paper copy of the treatment record for this exposure?**

Yes    No    Don't Know

**Was an electronic treatment record created for this exposure?**

Yes    No    Don't Know

**Is there anything else you would like to share with us about your animal exposure?**

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