



**Maine Department of Health and Human Services  
Maine Center for Disease Control and Prevention  
Division of Infectious Disease**

**Human Rabies Post-Exposure Prophylaxis (PEP) Reporting Form**

**Reporting Information**

Date of report:            \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Name of person reporting: \_\_\_\_\_ Title: \_\_\_\_\_  
 Agency/institution: \_\_\_\_\_ Phone: \_\_\_\_\_

**Patient Information**

Name (First, MI, Last): \_\_\_\_\_  
 Street address: \_\_\_\_\_  
 Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 County: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Date of birth:        \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age: \_\_\_\_\_ Gender:    Male    Female

**Provider Information**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Practice: \_\_\_\_\_ Practice town: \_\_\_\_\_

**PEP Administered**

Vaccine        Vaccine + Immune globulin

**Vaccine Information**

Facility where first dose administered: \_\_\_\_\_ Date of administration:        \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Immune Globulin Information**

Facility where administered: \_\_\_\_\_ Date of administration:        \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Exposure Information**

Date of exposure:        \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Town of exposure: \_\_\_\_\_  
 Type of exposure:    Bite        Scratch    Mucous membrane    Unknown  
                            Other:  
 Exposure site:        Leg        Face        Trunk        Arm        Hand/Finger  
                            Other:  
 Index animal type:    Cat        Dog        Ferret    Horse    Cow        Sheep  
                            Raccoon    Skunk    Fox        Bat        Woodchuck    Unknown  
                            Other:  
 Animal Status:        Owned    Stray    Wild    Unknown  
                           If owned, owner's name: \_\_\_\_\_ Owner telephone: \_\_\_\_\_

Describe exposure scenario:

Has an Animal Control Officer or other responder been contacted?    Yes    No    Unknown

Name of Officer: \_\_\_\_\_ Officer telephone: \_\_\_\_\_

**Clinical Information**

Is the patient immunosuppressed?    Yes    No    Unknown

Has the patient ever received rabies vaccine?    Yes    No    Unknown

If yes, reason:    Animal professional    Travel    Previous rabies exposure  
                            Other:

**Fax form to Division of Infectious Disease at (800) 293-7534**