ICMR-NATIONAL INSTITUTE OF VIROLOGY
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REQUEST FORM FOR RABIES TESTING (HUMAN CLINICAL SPECIMENS)

Patient Information			
Name of the patient: Mr./Mrs./Kum.:			
Age: _____*Years*____*Months*	**Gender:** *Male* □ *Female* □ *Others* □		**Hospital IP/OP No.:**
Name of spouse/parent/guardian: Mr./Mrs./Kum.:			
Address:			
Village/Town:	**Taluk:**	**District:**	**State:**
Referring Hospital:			
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** □		**Post-mortem testing for rabies** □
	Evaluation of seroprotection □		**Others (Specify):**

Exposure History (Please tick the relevant responses)			
Known history of exposure to a suspected/confirmed rabid animal:	*Yes* □	*No* □	*Unknown* □
If yes, date of exposure: __/__/20__	**Was this a repeat exposure?** *Yes* □	*No* □	*Unknown* □
Type of animal involved: *Domestic/pet* □ *Stray* □ *Wild* □	**Type of bite:** *Provoked* □	*Unprovoked* □	*Unknown* □
Species of animal involved	*Dog* □ *Cat* □ *Fox* □ *Jackal* □ *Cattle* □ *Sheep* □ *Goat* □ *Monkey* □		
	Mongoose □ *Bat* □ *Others (Specify):*		
Rabies vaccination status of the animal (if domestic/pet)	*Vaccinated* □	*Unvaccinated* □	*Unknown* □
Body part affected	*Head and neck* □ *Chest* □ *Abdomen* □ *Hands* □ *Fingers* □ *Thighs* □ *Legs* □		
	Toes □ *Genitals* □ *Others (Specify):*		
Category of Exposure	*Category I* □	*Category II* □	*Category III* □

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

Brief Clinical History

Does the patient meet the case definitions for rabies? (Please tick the relevant category)	Suspected case of rabies □	Probable case of rabies □	
Clinical presentation	Encephalitic □	Paralytic □	Atypical □

Laboratory and Imaging Findings (Please attach relevant copies)		
CSF	**Protein:**____*mg/dL*	**Glucose:** ____*mg/dL*
	Total cell count:_____*cells/mm^3*	**Differential count:**
CT Scan	**Done** □ **Not done** □	**Date performed:** ___/__/*20*__
	Summary findings:	
MRI Scan	**Done** □ **Not done** □	**Date performed:** ___/__/*20*__
	Summary findings:	
Findings from routine laboratory investigations		

Details of specimens submitted				
Sl. No.	Type of specimen (Please tick the relevant option)	Ante-mortem/post-mortem	Date of collection	Specimen ID (ICMR-NIV) (To be filled by laboratory)
1	Saliva □			
2	Cerebrospinal fluid □			
3	Neck skin biopsy □			
4	Brain tissue □			
5	Serum □ Whole blood □			
6	Others (Specify)			

Note:

- Please refer to the **Guidelines for Sample Collection, Storage, Packaging and Transport of Clinical Specimens for Rabies Testing**, given at **www.niv.icmr.org.in under 'Current Activities'→'Services/Outbreak Investigations**).
- We strongly recommend the submission of multiple types of specimens (as listed above), to improve the diagnostic performance and accuracy.
- For queries related to specimen submission and testing, please contact the **Encephalitis Group** (**+91-20-26006807/893**), **Virus Registry (+91-20-26006231) or Reception (+91-20-26006890/290)** of ICMR-National Institute of Virology, Pune, or email us in **encephalitisgroup2016@gmail.com**.

For Laboratory Use Only			
Date of receipt of samples: ___/__/*20*__	**Time of receipt:** ___:___ *HRS*	**Received by:**	
Quality Control Check	*Pass* □ *Fail* □ *If failed, reason:* _____		
Date of testing: ___/__/*20*__	**Tests done:**	*Real-time RTPCR* □ *SNRTPCR* □ *FAT* □ *RFFIT* □	
Date of issuing test report: ___/__/*20*__		*Others (Specify):*	

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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 ICMR-National Institute of Virology, Pune. I hereby **give / do not give** (*strike off whichever is not relevant)* my full consent to the ICMR-National Institute of Virology, Pune, Maharashtra, 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 ICMR-National Institute of Virology, Pune.
I hereby **give / do not give** (*strike off whichever is not relevant)* my full consent to the ICMR-National Institute of Virology, Pune, Maharashtra, 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