



ANIMAL BITE REPORT RABIES CONTROL INVESTIATION

DOH USE ONLY
Date Received: _____
Case Number: _____
Day 10: _____

1. Name of Person Bitten (Last, First)	2. <input type="checkbox"/> Male <input type="checkbox"/> Female	3. Date of Birth	4. Telephone
5. Address of Person Bitten			
City		State	Zip Code
6. Guardian	7. Part of body that was <input type="checkbox"/> bitten <input type="checkbox"/> scratched <input type="checkbox"/> exposed <input type="checkbox"/> contact		
8. Place of Attack		9. Date of Attack	
10. Circumstances of Attack: <input type="checkbox"/> Unknown <input type="checkbox"/> Playful <input type="checkbox"/> Provoked <input type="checkbox"/> Injured <input type="checkbox"/> Other _____			
11. Doctor seen? <input type="checkbox"/> Yes <input type="checkbox"/> No		Tetanus given? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Antibiotics Given: <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Last Tetanus:	
12. Type of Animal <input type="checkbox"/> Cat <input type="checkbox"/> Dog <input type="checkbox"/> Female <input type="checkbox"/> Owned <input type="checkbox"/> Spayed			
<input type="checkbox"/> Wild <input type="checkbox"/> Other _____ <input type="checkbox"/> Male <input type="checkbox"/> Stray <input type="checkbox"/> Neutered			
<input type="checkbox"/> Unknown <input type="checkbox"/> Unknown			
13. Animal Owner if known		14. Name of Animal, Breed, Color; Age of Animal	
15. Animal Owner's Address			
City		State	Zip Code
BELOW FOR HEALTH DEPARTMENT/ANIMAL SERVICES USE ONLY			
16. <input type="checkbox"/> Vaccinated <input type="checkbox"/> Unvaccinated Vet: Rabies Tag No. Vaccination Date <input type="checkbox"/> 1 YR <input type="checkbox"/> 3 YR			
<input type="checkbox"/> Unknown			
17. Has Quarantine Agreement been signed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unable to Locate Animal			
Location of Quarantine		From Date	To Date
18. Animal survived quarantine? <input type="checkbox"/> Yes <input type="checkbox"/> No Victim notified by: <input type="checkbox"/> Person <input type="checkbox"/> Phone <input type="checkbox"/> Mail			
Victim notified by: _____ Date: _____			
19. Cause of Death: <input type="checkbox"/> Illness <input type="checkbox"/> Injury <input type="checkbox"/> Euthanasia Date: _____			
20. Veterinarian <input type="checkbox"/> Did <input type="checkbox"/> Did Not See Animal		21. Head examination is: <input type="checkbox"/> Requested <input type="checkbox"/> Not Warranted	
22. Head Sent to Lab on: _____ Results: <input type="checkbox"/> POSITIVE <input type="checkbox"/> NEGATIVE <input type="checkbox"/> UNSATISFACTORY			
Victim notified by: _____ Date: _____			
23. <input type="checkbox"/> PEP Recommended <input type="checkbox"/> Accepted <input type="checkbox"/> Refused <input type="checkbox"/> Unable to make contact, certified letter mailed:			
24. Remarks:			
25. Case Closed by: _____		Date: _____	