



ANIMAL ENCOUNTER REPORT

COMPLETE AS MUCH INFORMATION AS POSSIBLE. FAX THIS REPORT OF THE BITE, SCRATCH, OR CONTACT WITH SALIVA, SPINAL FLUID, OR BRAIN TISSUE TO THE HEALTH DEPARTMENT IMMEDIATELY.

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ County: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Other Phone: _____ Date of Report: _____
Sex: Male Female Date of Birth: _____ Age (yrs, mos): _____
Ethnicity: American Indian or Alaska Native Asian Black Hawaiian (Native) or other Pacific Islander
Hispanic or Latino White

PARENT / GUARDIAN INFORMATION

Last Name: _____ First Name: _____ MI: _____ Relation: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Other Phone: _____ Work Phone: _____

PROVIDER INFORMATION

Physician: _____ Phone Number: _____
Facility: _____ Fax Number: _____
Address: _____ City: _____ State: _____ Zip: _____
Date Reported to Health Department: _____ Time: _____ By: _____

CIRCUMSTANCES OF BITE OR EXPOSURE

Exposure Date: _____ Time: _____
Type: Bite Scratch Contact with Saliva Unknown Other: _____
Location: Face/Head Neck Torso Abdomen Arm Hand Leg Foot
Exposure/Bite was: Provoked Unprovoked Animal Behavior: Normally Abnormal Unknown
Animal Restraint: Fence/Leash None/Roaming Not Applicable/Inside
_____ hours, _____ elapsed minutes between exposure and wound being cleansed with soap and water
Treatment: _____
P-E Prophylaxis: RIG Mfr: _____ Lot #: _____ Site: _____ Date: _____
Vaccine Mfr: _____ Lot #: _____ Site: _____ Date: _____
Patient Hospitalized for Exposure/Bite: Yes No Did patient die from Exposure/Bite: Yes No
Hospital: _____ Admission Date: _____ Date of Death: _____

ANIMAL INFORMATION

Owner: _____ Phone Number: _____ County: _____
Address: _____ City: _____ State: _____ Zip: _____
Species: _____ Pet Stray Wild If pet, Animal's Name: _____
Age: _____ Sex: Male Female Description (Breed): _____

THIS PAGE FOR HEALTH DEPARTMENT USE

INVESTIGATION INFORMATION

Person Interviewed: _____ Relation to Patient: _____ Date: _____

Patient's Pre-Exposure Status: Vaccinated Non-Vaccinated

Post-Exposure Status: Vaccinated Series Complete? Yes No If Yes, Date Completed: _____

Discussed PEP follow-up with physician: Yes No Sanitarian/Nurse: _____

Owner Notified: Yes No Date Notified: _____ By: Phone Letter Visit

Animal Vaccination current: Yes No (Confirm by certificate not tag, check vaccine listing reference in DC-4)

Vaccine Name: _____ Latest Vaccination Date: _____

Prior Vaccination History, if available: _____

Veterinarian: _____ Phone Number: _____

Status of Animal: Confined Killed Died Lost If Confined, Duration: _____ days

If Confined, At: Home Veterinarian Animal Shelter Date Confined: _____

Location address: _____

Other Animals Have Been Exposed: Yes No If Yes, Explain: _____

If Livestock involved, has Ag been contacted (Animal Health Division 558-2214): Yes No

Animal confined/quarantined for appropriate duration: Yes No Facilities adequate: Yes No

Dates Inspected: _____

LABORATORY INFORMATION
must be entered into EDSS

Animal Head Submitted for Examination: Yes No Date Submitted: _____

Lab ID #: _____

Positive Evidence of Rabies Virus Negative – No

Sample Unsatisfactory – No Test Performed Other Results – Specify: _____

Date Results Received: _____

Patient Notified of Results: Yes No Date: _____

INVESTIGATION FOLLOW-UP

Animal Health After 10 Days: Good Health Clinical Symptoms Escaped Died Lost to Follow-Up

Date Checked: _____ Signed: _____

Sanitarian Comments: _____

