Animal Bite Report Form

Informant Name: ___________________________ Date: ___________________________

Facility Name: ___________________________ Type: ☐ ER ☐ PCP ☐ Vet ☐ Other

If Rabies is suspected, please call Public Health Nursing: Van Buren Co 269-621-3143 – Cass Co 269-782-0064

Person Bitten:
Name: __________________________________ Phone: __________________________

Address: ___________________________ Phone: __________________________

Date of Birth: __________ Age: _______ Sex: ☐ female ☐ male

Alternative Contact name: ___________________________ Phone: __________________________

Bite or other exposure: ☐ Dog ☐ Cat ☐ Other:
Date: __________ Time: _______ am pm

Describe circumstances: __________________________________________________________

☐ Provoked  ☐ Unprovoked

Describe location and nature of injuries: _____________________________________________

About the animal:
Description of Animal: (age, sex, relevant history, breed (if known)

Animal’s Rabies immunization History:
☐ Unknown ☐ Unvaccinated ☐ Vaccinated, current ☐ Vaccinated, not current

Last shot given: ___________________________

Owner: ___________________________ Address: ___________________________ Phone: __________________________

Medical Follow up:
Comments: __________________________________________________________

Routine Follow-Up:
☐ Tetanus Immunization status checked ☐ Antibiotic Prophylaxis
☐ Wound cleaned with soap & water ☐ Disinfectant applied
☐ Victim cautioned about risk of infection

Rabies Post Exposure Prophylaxis: ☐ Recommended *Date initiated: __________ ☐ Not Recommended

For Public Health / Animal Control Use

Disposition of Animal and Recommendations
Plan for Animal: Additional information: (transportation details, etc.)
☐ Lost to follow-up
☐ Hold for 10-day observ.
☐ Discard/release (no risk)
☐ Send head to lab (batch)
☐ Send head to lab (express)
☐ Refer to Vet Diagnostics

Test Results:
☐ Not tested ☐ Negative
☐ Unsatisfactory ☐ positive

Faxed to Animal Control: Date: ___________ Initials: __________

Public Health Investigator: ___________________________ Date: __________