NORTH CENTRAL PUBLIC HEALTH DISTRICT
ANIMAL BITE REPORT FORM

419 East 7th St, The Dalles, OR 97058
Phone: 541-506-2600 Fax: 541-506-2601

Public Health
Prevent. Promote. Protect.

Medical Facility Staff will complete section 1-3.

1. Bitten Person *Please Print*

Last Name	First Name	Sex ☐ M ☐ F	Age	DOB _____/_____/_____
Address	Apt #	City	State	Zip
Phone	Other Phone	If a minor, Name of Parent/Guardian		

Race:
☐ White ☐ Black/African American ☐ Native American/Alaska Native ☐ Multiracial
☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Unknown

Ethnicity:
☐ Hispanic ☐ Non-Hispanic ☐ Unknown

2. Exposure Information (completed by medical facility staff)

Date of Exposure_____/_____/_____	Time: _____ AM _____ PM	Location (address)

Animal: ☐ Wild ☐ Domestic	☐ Dog ☐ Bat ☐ Ferret ☐ Cat ☐ Raccoon ☐ Skunk ☐ Unknown ☐ Other, specify _____	Description (Breed, Color, Sex)

Circumstances surrounding incident

(please describe): _____

_____

_____

_____

Type of Exposure:
☐ Bite
☐ Scratch
☐ Saliva to mucous membrane
☐ Other direct contact with animal (describe):_____
☐ Indirect contact with pet/animal following the animal's exposure to another suspect rabid animal
☐ Other_____
☐ Unknown (specify):_____

Bite Exposure
☐ Playful
☐ Sick/Hurt

3. About the Animal (completed by medical facility staff)

About the Animal:
☐ Victim's household pet ☐ Acquaintance's pet ☐ Stranger's Pet ☐ Stray ☐ Wild ☐ Unknown

Rabies Immunization History:
☐ Unknown ☐ Unvaccinated ☐ Vaccinated ☐ Last shot given ____/____/____

Medical Provider will complete section 4-7.

4. Medical Information

Seen by Medical Provider (MD)?		Provider (MD)Name
☐ Yes, Date of visit____/_____/_____ ☐ No ☐ Unknown		

Facility	Phone
Name of Primary Care Provider (PCP)	Phone

5. Treatment Information

Description of injury/location on the body:_____

_____

_____

_____

Recommended Further Prophylactic Treatment

HRIG (Human Rabies Immune Globulin)

☐ Yes, date given:_____/_____/_____

☐ No

HDCV (Human Diploid Cell Rabies Vaccine)

☐ Yes, date given:_____/_____/_____

☐ No

6. Person Completing Form

Name:_____ Phone:_____

Facility:_____ Date:_____

7. COMPLETE REPORT & FAX TO 541-506-2601. INCLUDE COPY OF ER DISCHARGE SUMMARY.

FOR HEALTH DEPARTMENT USE ONLY

Name of Person Bitten: _____

Rabies Risk Estimate:	**Test Results**
☐ Minimal ☐ Moderate ☐ High Risk	☐ Not tested ☐ Negative ☐ Unsatisfactory ☐ Positive
Laboratory	**Post-Exposure Rabies Prophylaxis**
☐ OSPHL (Hillsboro) ☐ VDL (Corvallis) ☐ CDC	Recommended by HD? ☐ Yes ☐ No Given to victim? ☐ Yes ☐ No ☐ Unknown

Comments: