

Animal Encounter Report Form

SG-58 REV. 10/12

FOR HEALTHCARE PROVIDER/FACILITY ATTENDING TO ANIMAL BITE PATIENT

Note to Providers: Complete as much information as possible on form. Fax this report to the local health department IN *COUNTY LISTED immediately.

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PATIENT DEMOGRAPHICS

Name (last, first): _____		Birth date: ____/____/____	Age: ____
Address (mailing): _____		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unk	
Address (physical): _____		Ethnicity: <input type="checkbox"/> Not Hispanic or Latino	
City: _____	State: _____	<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Unk
Zip: _____	*COUNTY: _____	Race: <input type="checkbox"/> White <input type="checkbox"/> Black/Afr. Amer.	
Phone (home): _____	Phone (work/cell): _____	<input type="checkbox"/> Asian <input type="checkbox"/> Am. Ind/AK Native	
Alternate contact: <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Spouse <input type="checkbox"/> Other		(Mark all that apply) <input type="checkbox"/> Native HI/Other PI	<input type="checkbox"/> Unk
Name: _____		Phone: _____	

PROVIDER INFORMATION

Physician: _____	Phone: _____	Fax: _____
Facility: _____	Address: _____	
City/State/Zip: _____	Date reported to health department: ____/____/____	

BITE/EXPOSURE INFORMATION

Exposure date: ____/____/____	Circumstances of Bite/Exposure
Exposure Type Y N U <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bite <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Scratch <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Saliva/CNS tissue contact with fresh* wound <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Saliva/CNS tissue contact with mucous membrane <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bat exposure with no definite bite or scratch <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other (Describe: _____) *Fresh wound=a wound that has bled within past 24 hours	Y N U <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bite or scratch caused a break in the skin If yes, where on body (mark all that apply): <input type="checkbox"/> Head/neck/face <input type="checkbox"/> Hand <input type="checkbox"/> Leg <input type="checkbox"/> Torso/chest/back <input type="checkbox"/> Arm <input type="checkbox"/> Foot <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Exposure was provoked <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Animal was behaving abnormally Veterinarian Name: _____ Veterinarian Phone Number: _____

CLINICAL INFORMATION

Hospitalization Y N U <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Patient hospitalized for this exposure If yes, hospital name: _____ Admit date: ____/____/____ Discharge date: ____/____/____	Treatment Y N U <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Patient wound cleaned <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Patient started rabies PEP series If yes, name of facility initiating PEP series: _____ If yes, did patient complete series?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Please document known vaccination dates below: #1: ____/____/____ #2: ____/____/____ #3: ____/____/____ #4: ____/____/____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Patient received human rabies immune globulin (RIG) If yes, RIG date: ____/____/____
Death Y N U <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Patient died due to this exposure If yes, date of death: ____/____/____	
Vaccination History Y N U <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Patient previously received rabies vaccine prior to this exposure If yes, date of previous vaccination: ____/____/____	

ANIMAL INFORMATION

Species Causing Exposure (mark all that apply): <input type="checkbox"/> Bat <input type="checkbox"/> Fox <input type="checkbox"/> Raccoon <input type="checkbox"/> Cat or kitten <input type="checkbox"/> Goat <input type="checkbox"/> Rodent <input type="checkbox"/> Cow <input type="checkbox"/> Horse <input type="checkbox"/> Sheep <input type="checkbox"/> Coyote <input type="checkbox"/> Monkey <input type="checkbox"/> Skunk <input type="checkbox"/> Dog or puppy <input type="checkbox"/> Pig <input type="checkbox"/> OTHER (list): _____ <input type="checkbox"/> Ferret <input type="checkbox"/> Rabbit _____	Ownership status of animal: <input type="checkbox"/> Owned (pet, livestock, etc.) Owner Name: _____ Owner Address: _____ City/State/Zip: _____ Owner Phone: _____ <input type="checkbox"/> Non-owned (wild, stray, etc.) <input type="checkbox"/> Unknown
Total number of animals involved in encounter: _____	

Additional notes: Animal(s) Name: _____ Age: _____ BREED: _____
COLOR DESCRIPTION: _____ CIRCLE: Female or Male CIRCLE: Provoked or Unprovoked