



ANIMAL BITE / RABIES EXPOSURE REPORT

Rick Scott
Governor

*All animal bites or other significant exposures are reportable by F.A.C. 64D-3

The Florida Department of Health in Escambia County can be reached at 850-595-6700 or after hours at 850-418-5566

To Be Completed By Patient	Patient Information			
	Name	Date of Birth	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F
	Address	City	State	Zip County
	Contact Phone Number	Parent/Guardian Name (if Minor)		
	Exposure Information			
	Date and Time of Bite/Exposure	Place of Animal Bite/Rabies Exposure (Address or Nearest Cross street)		
	Animal was provoked, (eating, injured, protecting offspring/territory, disturbed while sleeping, playing, startled)? <input type="checkbox"/> Yes <input type="checkbox"/> No Animal was unprovoked? <input type="checkbox"/> Yes <input type="checkbox"/> No Remarks/Description:			
	Type of Animal: <input type="checkbox"/> Dog <input type="checkbox"/> Cat <input type="checkbox"/> Other _____	Breed	Color	Age
	Sex of Animal: <input type="checkbox"/> M <input type="checkbox"/> F	Status: <input type="checkbox"/> Spayed/Neutered <input type="checkbox"/> Unaltered <input type="checkbox"/> Unknown		
	Health of Animal: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown <input type="checkbox"/> Deceased			
Animal is: <input type="checkbox"/> Owned <input type="checkbox"/> Stray <input type="checkbox"/> Wild <input type="checkbox"/> Unknown	Animal Name			
If owned, by whom? <input type="checkbox"/> Self <input type="checkbox"/> Other				
Name of Owner	Contact Phone of Owner			
Address of Animal Owner	City	State	Zip	
Has the animal been vaccinated for Rabies? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If YES give the last vaccination date ____/____/____				
Tag Number	<input type="checkbox"/> 1 Year Vaccine <input type="checkbox"/> 2 Year Vaccine <input type="checkbox"/> 3 Year Vaccine			
Veterinarian/Clinic Name				
Location of Animal (if different from owner's address)				
<input type="checkbox"/> Unable to locate	<input type="checkbox"/> Animal Confined	If confined: From Date:	To Date:	
To Be Completed By Hospital Staff	Treatment Information			
	Description of injury <input type="checkbox"/> Bite <input type="checkbox"/> Scratch <input type="checkbox"/> Other _____			
	Location of injury <input type="checkbox"/> Face <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Mouth <input type="checkbox"/> Eyes <input type="checkbox"/> Check if above the neck/shoulder <input type="checkbox"/> Torso/Trunk <input type="checkbox"/> Hand/Arm <input type="checkbox"/> Leg/Foot <input type="checkbox"/> Other _____			
	Date of Treatment	Treating Physician (Name & Phone Number)		
	Was the wound washed/flushed at the facility? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Wound Care (Check all that apply) <input type="checkbox"/> Washed/Flushed <input type="checkbox"/> Sutured <input type="checkbox"/> Other: _____ <input type="checkbox"/> Tetanus Vaccine <input type="checkbox"/> Antibiotics			
	Anti-rabies treatment recommended <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Anti-rabies treatment received <input type="checkbox"/> Yes <input type="checkbox"/> No If YES <input type="checkbox"/> HRIG + Vaccine <input type="checkbox"/> Vaccine ONLY			
If anti-rabies treatment not initiated, Why? <input type="checkbox"/> Waiting for animal lab/quarantine results <input type="checkbox"/> Referred to other facility <input type="checkbox"/> Patient Refused Reason _____				
Form Completed By (Print Name)		Hospital /Facility Name		
Phone Number		Fax Number		
Animal Control	Animal ID #	Kennel #	Complaint #	
	Officer Name	Officer Phone Number		

Fax Completed Form to FDOH-Escambia, Environmental Health 850-595-6792