



ANIMAL BITE / RABIES EXPOSURE REPORT

Ron DeSantis
Governor

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

Joseph A. Ladapo, MD, PhD
State Surgeon General

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"/> Torso/Trunk <input type="checkbox"/> Hand/Arm <input type="checkbox"/> Leg/Foot <input type="checkbox"/> Other _____ <input type="checkbox"/> Check if above the neck/shoulder			
	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