

**Monroe County Department of Health**

Animal Bite/Contact Report - 1 Patient Per Form  
To be Completed by Health Care Provider; Not Patient

DOH 485# \_\_\_\_\_

**\*Notify MCDOH of All Animal Bites / Contact incidents \***

**Fax Report to 753-6014**

**Non-Routine Exposures:** Bite or Contact with Saliva From Wildlife or Domestic Animal Not Vaccinated Against Rabies.  
*Notify Immediately by Phone: 753-5864 Weekdays (8:30 a.m. - 4:30 p.m.), 753-5905 after-hours & weekends*

**Routine Exposures:** Bite or Saliva Contact From Domestic Animal Currently Vaccinated Against Rabies and Individuals Bitten by Their Own Pet. Fax Report to 753-6014.

**Patient/Victim Information**

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_  Male  Female

Address: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Parent Name (If Pt<18): \_\_\_\_\_

County of Incident: \_\_\_\_\_ Reported By: \_\_\_\_\_ Phone: \_\_\_\_\_

**Incident Information**

Date of Bite/Contact: \_\_\_\_\_ Time: \_\_\_\_\_ a.m. or p.m. (Circle 1)

Describe the Incident and Exposure: \_\_\_\_\_

\_\_\_\_\_

Site of Bite Wound \_\_\_\_\_

**Animal Information**

Owner of Animal: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Species: \_\_\_\_\_ Breed: \_\_\_\_\_  Domestic  Wild/Stray

Vaccinated for Rabies:  Yes  No  Unknown Animal Name: \_\_\_\_\_ Age: \_\_\_\_\_

Vaccination Date: \_\_\_\_\_ Exp. \_\_\_\_\_

Veterinarian: \_\_\_\_\_ Phone: \_\_\_\_\_

Was Bite/Scratch Provoked?  Yes  No

Animal Behavior:  Normal  Aggressive  Sick Appearance

**\*Contact MCDOH prior to starting Rabies Prophylaxis\*** (see contact #'s above)

**Post Exposure Rabies Prophylaxis Initiated?**  Yes  No Date: \_\_\_\_\_

RIG Dose/Site: \_\_\_\_\_

HDCV Dose/Site: \_\_\_\_\_

Private Physician: \_\_\_\_\_

Insurance:  Blue Cross/Blue Shield  Blue Choice  Preferred Care  Medicaid  Other \_\_\_\_\_

Patient will need to call MCDOH to arrange for follow-up treatment

Form Completed By (Name, Date & Time): \_\_\_\_\_

