

# Animal Encounter Report Form

SG-58 REV. 10/12

FOR HEALTHCARE PROVIDER/FACILITY ATTENDING TO ANIMAL BITE PATIENT

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**Note to Providers:** Complete as much information as possible on page 1 of this form. Fax this report to the local health department immediately.

## 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/Zip: _____		<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Unk	
Phone (home): _____	Phone (work/cell): _____	Race: <input type="checkbox"/> White <input type="checkbox"/> Black/Afr. Amer.	
Alternate contact: <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Spouse <input type="checkbox"/> Other		<input type="checkbox"/> Asian <input type="checkbox"/> Am. Ind/AK Native	
Name: _____ Phone: _____		(Mark all that apply) <input type="checkbox"/> Native HI/Other PI <input type="checkbox"/> Unk	

## PROVIDER INFORMATION

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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

City/State/Zip: \_\_\_\_\_ Date reported to health department: \_\_\_/\_\_\_/\_\_\_

## BITE/EXPOSURE INFORMATION

Exposure date: ___/___/___	<b>Circumstances of Bite/Exposure</b>
<b>Exposure Type</b> 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 <b>with fresh* wound</b> <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: _____) <small>*Fresh wound=a wound that has bled within past 24 hours</small>	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

## CLINICAL INFORMATION

<b>Hospitalization</b> 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: ___/___/___	<b>Treatment</b> 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 <b>complete series?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Please document known vaccination dates below: #1: ___/___/___ #2: ___/___/___ #3: ___/___/___ #4: ___/___/___
<b>Death</b> Y N U <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Patient died due to this exposure If yes, date of death: ___/___/___	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Patient received human rabies immune globulin (RIG) If yes, RIG date: ___/___/___
<b>Vaccination History</b> 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

<b>Species Causing Exposure</b> (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 _____	<b>Ownership status of animal:</b> <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:

**INVESTIGATION SUMMARY**

Local Health Department (Jurisdiction): \_\_\_\_\_ Entered in WVEDSS?  Yes  No  Unk  
 Investigation Start Date: \_\_/\_\_/\_\_\_\_ Case Classification:  
 Earliest date reported to LHD: \_\_/\_\_/\_\_\_\_  Confirmed  Probable  Suspect  
 Earliest date reported to state: \_\_/\_\_/\_\_\_\_  Not a case  Unknown

Was owner contacted?  Yes  No Date Notified: \_\_/\_\_/\_\_\_\_ By:  Phone  Letter  Visit

**Rabies Vaccination Status of Animal:**

If pet or livestock, were rabies vaccinations up-to-date\*?  Yes (Date: \_\_/\_\_/\_\_\_\_)  No  Unknown  
 \*For cats, dogs and ferrets: 1<sup>st</sup> Dose @3mo, Booster @ 1yr; Booster every 1-3 yrs (depending on manufacturer)  
 Veterinarian: \_\_\_\_\_ Phone: \_\_\_\_\_

**EXPOSURE INFORMATION**

**Y N U**  
   Occupational exposure If yes, indicate occupation: \_\_\_\_\_  
   Exposure occurred outside the United States (If yes, please call DIDE immediately for consult)  
   Exposure occurred in a county with a history of animal rabies activity  
 Where did exposure occur? County: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_

**OBSERVATION TIMELINE**

**Observation\* Period**

<b>+0 days</b> (Exposure date)	<b>+10 days</b> (Check Date)
Calendar dates: __/__/____	Calendar dates: __/__/____
MM/DD/YYYY	MM/DD/YYYY

*Instructions: enter exposure date in grey box. Count forward 10 days to determine observation period*

\*Period of observation for cats, dogs and ferrets is 10 days. For livestock, 14 days are recommended. Confinement of other species not appropriate.

**ANIMAL FOLLOW UP INFORMATION**

**Y N U**  
   Animal involved in exposure was able to be confined  
 if yes, indicate # days (from exposure to final check): \_\_\_\_ and final status:  Healthy  Died  Lost  Other: \_\_\_\_\_  
 If yes, indicate where animal confined:  Home  Animal Shelter  Veterinarian  Other: \_\_\_\_\_  
   Animal confinement not possible, but animal was able to be observed following the exposure  
 (if yes, indicate # days (from exposure to observation): \_\_\_\_ and final status:  Healthy  Died  Lost  Other: \_\_\_\_\_)  
   Other Animals Have Been Exposed (if yes, explain: \_\_\_\_\_)  
   If livestock involved, has Ag been contacted (304-558-2214)

**LABORATORY INFORMATION**

**Y N U**  
   Animal involved in exposure was submitted for rabies testing (If yes, date: \_\_/\_\_/\_\_\_\_ and Lab ID#: \_\_\_\_\_)  
   Rabies virus detected in exposing animal via direct fluorescent antibodies (DFA) (If yes, date: \_\_/\_\_/\_\_\_\_)  
   Patient notified of results (if applicable) (If yes, date: \_\_/\_\_/\_\_\_\_)

**PUBLIC HEALTH ISSUES**

**Y N U**  
   Human exposure to an animal that was lost-to-follow-up  
   Human exposure to an animal that was euthanized or killed and not available for testing  
   Other:

**PUBLIC HEALTH ACTIONS**

**Y N U**  
   Rabies education provided to patient  
   Patient referred to healthcare provider  
   Rabies PEP recommended to patient  
   Referred patient to national indigent rabies vaccine program  
   National B Virus Resource Center contacted to assist with exposure management (for exposures involving primates only)  
   Responsible pet ownership education provided to animal (i.e., spay/neuter, rabies vaccine, caution w/young children)  
   Outreach provided to employer to reduce employee risk (for occupationally-related exposures)  
   Patient lost to follow-up  
   Other:

**NOTES**

\_\_\_\_\_