

REPORT OF ANIMAL BITE/EXPOSURE
(Complete a separate form for each person)

REPORT INFORMATION IMMEDIATELY TO:
CLINTON COUNTY DEPARTMENT OF HEALTH, ENVIRONMENTAL DIVISION
133 Margaret Street, Plattsburgh, NY 12901
(518) 565-4870 (Phone) / (518) 565-4843 (Fax)

INFORMATION TAKEN BY _____ TITLE _____ DATE _____

PERSON BITTEN/EXPOSED _____ D.O.B. _____ PARENTS NAME _____

MAILING ADDRESS _____

HOME PHONE _____ BUS. PHONE _____ MES. PHONE _____

DATE OF BITE/EXPOSURE _____ TOWNSHIP WHERE BITE/EXP. OCCURRED _____

DESCRIBE LOCATION OF BITE/EXPOSURE _____

HOW BITE/EXPOSURE OCCURRED _____

WAS ANIMAL EXHIBITING UNUSUAL BEHAVIOR? NO _____ YES _____

ATTENDING MD _____ HOSP/CLINIC _____ PHONE _____

FAMILY MD _____ HEALTH INS. CO. _____ I.D. NO. _____

ANIMAL DATA

SPECIES _____ BREED _____ SEX _____

DESCRIPTION _____ NAME _____

OWNER _____ HOME PHONE _____ BUS. PHONE _____

OWNER'S MAILING ADDRESS _____

ANIMAL IS : _____ DOMESTIC _____ STRAY _____ WILD

STATUS : _____ ALIVE _____ DEAD IF KILLED, DATE _____

MEANS _____

DATE OF LAST RABIES VACCINATION? _____ VET _____

IS RABIES KNOWN OR SUSPECTED TO BE PRESENT IN SPECIES & AREA? _____ YES _____ NO

COMMENTS: _____

FOR HEALTH DEPARTMENT USE ONLY

PATIENT'S NAME _____ **PATIENT #** _____

ANIMAL CONFINEMENT & VACCINATION STATUS

Alive, Well & Available for 10-Day Confinement?	Yes	No	Initials	Date
Current Rabies Vacc. At Time of Bite?				
Confinement Explained to _____ (Responsible Adult)				
Confinement Letter Sent*(Attach Copy) VACC/UNVACC (Circle one) *If unable to confirm vaccination within 24 hrs. send "unvaccinated" letter				
To be Confined at ___ HOME or ___ APPROVED FACILITY: _____ Phone: _____				
Delivered to Facility on _____ (Date)				
Alive and Well After 10 Day Conf. (_____)				
OK Given to Release From Conf. Facility?				
Vaccination Given After 10 Day Conf.?				
If no Vaccination, R-Letter Sent (Attach Copy) IF Not Sent, Give Reason: _____				

ANIMAL TESTING

Vet Office Handling Specimen:			Phone:		
Specimen Sent To Rabies Lab?	NO _____	Yes _____	Sent By	Carrier	Date
Test Results	NEG _____	POS _____	UNSAT _____	LAB NO.	Date
Patient Notified of Results?				By	Date
Veterinarian or Other Interested Party Notified?				By	Date

HUMAN POST EXPOSURE TREATMENT

Human Exposure Evaluation Form Completed.....By _____ Date _____
 Copy of Paperwork to Intake RN, HSU.....By _____ Date _____
 CVPH Medical Center Emergency Department Notified.....By _____ Date _____
 List Other Persons Possibly exposed to Same Animal:

DOMESTIC ANIMAL EXPOSED TO RABID OR SUSPECT RABID ANIMAL

Owner Questioned By _____ Date _____
 Exposure Occurred Yes _____ No _____
 "DISPOSITION OF ANIMALS" Form Completed By _____ Date _____

TO BE COMPLETED BY PROGRAM SUPERVISOR

Rabies Report (DOH 485) Completed By _____ Date _____
 Map Updated By: _____ Date _____
 Data Entry By: _____ Date _____