

Submitter Information:

1. Reason for Rabies Testing

- Human Exposure (complete sections 2A, 3, 4, 5)
- Animal Exposure (complete sections 2B, 3, 4, 5)
- Other (complete sections 3, 4, 5)
specify _____

2. Exposure Information (complete section 2A for human exposure, 2B for animal exposure)

2A. Person Exposed **Exposure Date** ___/___/___ (if more than one person exposed, complete back of form)

Name _____
 Address _____
 City/State/Zip _____
 Date of Birth _____ Age _____ Sex _____
 Phone #: 1st (_____) _____ 2nd (_____) _____

Physician (required**)**

Name _____
 Clinic Name _____
 Street Address _____
 City/State/Zip _____
 Physician Phone (_____) _____

Type of Exposure:

- Bite Scratch
- Lick Unknown
- Other _____

Anatomical Site _____

Post Exposure Treatment:

- Vaccine Yes No Date initiated _____
- HRIG Yes No Date initiated _____
- None

2B. Animal Exposed **Exposure Date** ___/___/___ (if more than one animal exposed, complete back of form)

Species _____ Age _____
 Rabies Vaccination Current? Yes No Unkn

Owner (of exposed animal) _____

Type of Exposure:

- Bite Scratch
- Ingestion Unknown
- Lick Other _____

Anatomical Site _____

Address _____

City/State/Zip _____

3, 4 & 5 Specimen Submission Information

3. Specimen Information

Species _____ Domestic-Owned
 Age _____
 Rabies Vaccination Current? Yes No Unkn
 Date of last vaccination: ___/___/___
 Vaccine lot _____ manufacturer _____
 Animal vaccinated prior to last vaccine: Yes No

Number of animals submitted for testing: _____

Domestic-Stray/Feral Wild Unknown

Date of Death ___/___/___ Died Euthanized

Animal Signs:

- Aggressive Ataxia Convulsion
- Depression Disorientation Frothing
- Howling/Bellowing Nausea Paralyzed
- Shallow Respiration Other _____

Owner (of submitted animal) _____

Address _____

City/State/Zip _____

Phone # (_____) _____

4. Veterinarian

Name _____

Phone # (_____) _____

Address _____

City/State/Zip _____

5. Local Health Department Jurisdiction

WSLH Use only

Additional Human Exposure Information

2A. 2nd Person Exposed		Exposure Date ____/____/____
Name _____	Physician (**required**)	
Address _____	Name _____	
City/State/Zip _____	Clinic Name _____	
Date of Birth _____ Age _____ Sex _____	City/State/Zip _____	
Phone #: 1st (_____) _____ 2nd (_____) _____	Physician Phone (_____) _____	
Type of Exposure:	Anatomical Site	Post Exposure Treatment:
<input type="checkbox"/> Bite <input type="checkbox"/> Scratch <input type="checkbox"/> Lick <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____		Vaccine <input type="checkbox"/> Yes <input type="checkbox"/> No Date initiated _____ HRIG <input type="checkbox"/> Yes <input type="checkbox"/> No Date initiated _____ None <input type="checkbox"/>

2A. 3rd Person Exposed		Exposure Date ____/____/____
Name _____	Physician (**required**)	
Address _____	Name _____	
City/State/Zip _____	Clinic Name _____	
Date of Birth _____ Age _____ Sex _____	City/State/Zip _____	
Phone #: 1st (_____) _____ 2nd (_____) _____	Physician Phone (_____) _____	
Type of Exposure:	Anatomical Site	Post Exposure Treatment:
<input type="checkbox"/> Bite <input type="checkbox"/> Scratch <input type="checkbox"/> Lick <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____		Vaccine <input type="checkbox"/> Yes <input type="checkbox"/> No Date initiated _____ HRIG <input type="checkbox"/> Yes <input type="checkbox"/> No Date initiated _____ None <input type="checkbox"/>

Additional Animal Exposure Information

2B. 2nd Animal Exposed		Exposure Date ____/____/____
Species _____	Age _____	
Rabies Vaccination Current? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unkn		Owner (of exposed animal) _____
Type of Exposure:	Anatomical Site	Address _____
<input type="checkbox"/> Bite <input type="checkbox"/> Scratch <input type="checkbox"/> Ingestion <input type="checkbox"/> Unknown <input type="checkbox"/> Lick <input type="checkbox"/> Other _____		City/State/Zip _____

2B. 3rd Animal Exposed		Exposure Date ____/____/____
Species _____	Age _____	
Rabies Vaccination Current? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unkn		Owner (of exposed animal) _____
Type of Exposure:	Anatomical Site	Address _____
<input type="checkbox"/> Bite <input type="checkbox"/> Scratch <input type="checkbox"/> Ingestion <input type="checkbox"/> Unknown <input type="checkbox"/> Lick <input type="checkbox"/> Other _____		City/State/Zip _____