REPORT OF ANIMAL BITE - POTENTIAL RABIES EXPOSURE

(Please read Privacy Act Statement before completing this form.)

SEQUENCE NUMBER

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. Section 3013, Secretary of the Army; 10 U.S.C. 5013, Secretary of the Navy; 10 U.S.C. 8013, Secretary of the Air Force; DoD Directive 6400.4, DoD Veterinary Services Program; AR 4-905, SECNAVIST 6401.1B, AFI 48-131, Veterinary Health Services; and E.O. 9397 (SSN).

PRINCIPAL PURPOSE(S): Used by medical authorities to record the history, examination, and treatment of a person who has possibly been exposed to rabies; and to record the follow-up medical care provided to the patient. Used by veterinarians to locate the animal, record examination, observations, and disposition results, and possible laboratory findings for the animal.

ROUTINE USE(S): The DoD "Blanket Routine Uses" that appear at the beginning of the Army's compilation of systems of records apply to this system. Information may be disclosed to aid in preventive health and communicable disease control programs and report medical conditions to Federal, state and local agencies, required by law.

DISCLOSURE: Voluntary. However, failure to provide all the requested information may result in the improper treatment and care being administered to the patient.

1. FROM *(Medical Treatment Facility)*	**2. THRU** *(Veterinary Service Activity)*	**3. TO** *(Chief, Preventive Medicine)*

PART I - ANIMAL BITE HISTORY *(To be completed by Emergency Room or Primary Care Interviewer)*

4. DESCRIPTION OF ANIMAL					**5. TIME OF ATTACK**	
a. TYPE *(Dog, cat, etc.)*	b. BREED	c. SIZE	d. COLOR	e. SEX	a. DATE *(YYYYMMDD)*	b. HOUR

6. PRESENT LOCATION OF ANIMAL OR GEOGRAPHIC ADDRESS WHERE ATTACKED ☐ ON POST ☐ OFF POST

7. CIRCUMSTANCES LEADING TO BITE/SCRATCH INCIDENT

8. APPARENT HEALTH OF ANIMAL *(Unusual Behavior)*

9. ANIMAL OWNER

a. NAME *(Last, First, Middle Initial)*	b. STATUS *(X one)*	c. PHONE NUMBER *(Include Area Code)*	d. ADDRESS *(Street, City, State, Zip Code)*
	☐ MILITARY ☐ CIVILIAN		

10. RABIES VACCINATION

a. VACCINATION STATUS OF ANIMAL	b. YEAR ANIMAL VACCINATED	c. TYPE VACCINE *(If known)*

11. FORM PREPARED BY

a. NAME *(Last, First, Middle Initial)*	b. TITLE	
c. SIGNATURE	d. DEPARTMENT/SERVICE/CLINIC	e. DATE PREPARED *(YYYYMMDD)*

12. PATIENT'S IDENTIFICATION *(ID impression, if available.) (For typed or written entries give name (Last, First, Middle Initial); pay grade; SSN; unit; duty and home telephone numbers; date; hospital or medical facility.)*

PART II - MANAGEMENT OF ANIMAL BITE CASE *(To be completed by Medical Officer (Information from SF 600))*

13. DESCRIPTION OF INJURY AND LOCATION ON THE BODY

14. DIAGNOSIS *(Injury) (X as applicable)*

	ANIMAL BITE		CLAW WOUND		OTHER

15. RABIES RISK ESTIMATE *(X one)*

	MINIMAL		MODERATE		HIGH RISK

16. INITIAL TREATMENT GIVEN *(X and complete as applicable)*

a. TIME	b. DATE *(YYYYMMDD)*

- c. DEEP FLUSHING AND CLEANSING WITH SOAP AND WATER
- d. TETANUS PROPHYLAXIS *(List dose given)*
- e. ASSESSMENT OF IMMUNOCOMPETENCE AND NEED FOR ANTIBIOTIC USE
- f. OTHER *(Specify)*

17. RECOMMENDED FURTHER PROPHYLACTIC TREATMENT *(X as applicable)*

- a. NONE
- b. HUMAN RABIES IMMUNE GLOBULIN *(Consult in accordance with Service/local policy prior to treatment)*
- c. HUMAN DIPLOID CELL RABIES VACCINE
- d. COUNSELED ON INFECTIOUS RISK OF ORAL FLORA
- e. OTHER *(Specify)*

18. PHYSICIAN

a. NAME *(Last, First, Middle Initial)*	b. SIGNATURE

19. ARMY VETERINARIAN

a. CONTACTED *(X one)*		YES		NO

b. NAME OF VETERINARIAN *(If applicable) (Last, First, Middle Initial)*

20. VERBAL REPORT TO

	(1) NAME *(Last, First, Middle Initial)*	(2) TELEPHONE	(1) NAME *(Last, First, Middle Initial)*	(2) TELEPHONE
a. PM/PUBLIC HEALTH			c. OTHER *(List)*	
b. POLICE				

PART III - MANAGEMENT OF BITING ANIMAL *(To be completed by Veterinarian)*

21. AUTHORITIES NOTIFIED *(Local public health authorities, law enforcement, etc.)*

a. NAME *(Last, First, Middle Initial)*	b. DATE *(YYYYMMDD)*	c. TIME	d. INITIALS	e. FOLLOW-UP (1) DATE *(YYYYMMDD)*	e. FOLLOW-UP (2) TIME

22. INITIAL ACTION

23. FORM RECEIVED BY VETERINARY SERVICES

a. TIME	b. DATE *(YYYYMMDD)*	c. INITIALS

24. LOCATION OF ANIMAL DURING OBSERVATION PERIOD *(On or off post, list point of contact if not veterinary activity)*

25. OBSERVED BY *(Include name of military or civilian agency)*

26. DATES OBSERVED *(YYYYMMDD)*

a. FROM	b. TO

27. DATE ANIMAL RELEASED FROM QUARANTINE *(YYYYMMDD)*

PATIENT'S IDENTIFICATION *(ID impression, if available.) (For typed or written entries give name (Last, First, Middle Initial); pay grade; SSN; unit; duty and home telephone numbers; date; hospital or medical facility.)*

PART III - MANAGEMENT OF BITING ANIMAL *(Continued)*

28. CONDITION OF ANIMAL DURING AND AT THE END OF 10-DAY QUARANTINE *(Explain fully - healthy, died, escaped, not located, etc.)*

29. OTHER INFORMATION OR COORDINATION *(Including notification of animal status to ER or MTF; list names and dates)*

30. LABORATORY FINDINGS OF ANIMAL SUBMITTED FOR RABIES DIAGNOSIS

a. TEST *(X one)*	b. DATE RECEIVED *(YYYYMMDD)*	c. RESULTS *(X one)*	
☐ (1) FLUORESCENT ANTIBODY		☐ NEGATIVE	☐ POSITIVE
☐ (2) CELL CULTURE		☐ NEGATIVE	☐ POSITIVE

31. VETERINARY OFFICER

a. NAME *(Last, First, Middle Initial)*	b. SIGNATURE	c. DATE SIGNED *(YYYYMMDD)*

PART IV - RABIES ADVISORY BOARD OR OTHER MEDICAL CONSULTATION/COORDINATION

32. DISCUSSED BY *(List names, or X box at right.)* ☐ NOT REQUIRED TO MEET

33. RECOMMENDATIONS

☐	a. HUMAN RABIES IMMUNE SERUM *(X one)*	☐	LOCAL	☐	SYSTEMIC	☐	BOTH
☐	b. VACCINE						
☐	c. OTHER						

34. CHIEF, PREVENTIVE MEDICINE

a. NAME *(Last, First, Middle Initial)*	b. SIGNATURE	c. DATE SIGNED *(YYYYMMDD)*

35. FINAL DISPOSITION OF CASE

36. MEDICAL OFFICER REVIEW *(In accordance with Service/local policy)*

a. SIGNATURE	b. DATE SIGNED *(YYYYMMDD)*

PATIENT'S IDENTIFICATION *(ID impression, if available.) (For typed or written entries give name (Last, First, Middle Initial); pay grade; SSN; unit; duty and home telephone numbers; date; hospital or medical facility.)*