SRHD Date Received Stamp

Medical Provider Animal Bite Report Form

THIS PAGE TO BE COMPLETED BY MEDICAL PROVIDER

Complete and forward report to Spokane Regional Health District to evaluate risk of rabies transmission if biting animal is ill or DOA, if victim is severely injured, or if the answer to ANY of the following questions is YES or Unknown:

☐Yes ☐No ☐Unk **Victim is severely injured** (e.g., broken bones, disfigurement, requires sutures or surgery, multiple bites)
If Yes, explain:

☐Yes ☐No ☐Unk Biting animal is aggressive or has neurological symptoms (e.g., not eating/drinking, paralysis, behavior change)

☐Yes ☐No ☐Unk Biting animal could be a stray (owner currently unknown)

☐Yes ☐No ☐Unk Biting animal is a wild/feral animal

☐Yes ☐No ☐Unk Biting animal is a domestic/wild animal hybrid (dom. dog/wolf or coyote hybrid, dom. cat/cougar hybrid, etc.)

☐Yes ☐No ☐Unk Biting animal has traveled outside of WA, ID or OR within the last 6 months or is from outside of WA, ID or OR
If Yes or Unk., explain:

☐Yes ☐No ☐Unk There is evidence the biting animal had contact with a wild animal within the last 6 months (e.g., dead bat found, fight with raccoon, coyote) **If YES, explain:**

VICTIM INFORMATION

TODAY'S DATE:

Who reported the bite?: ☐ Victim or Name: Relationship to Victim:

Phone (of Person Reporting Bite):

Victim's Name: DOB: Sex: ☐ M ☐ F

Victim's Address: Zip Code:

Victim's Home Telephone: Cell (Alternate):

Parent/Guardian Name: Phone:

Was skin broken? ☐ Yes ☐ No ☐ Single Bite ☐ Multiple Bites ☐ Scratch ☐ Stitches

Anatomical site of bite(s):

INCIDENT

DATE OF BITE/INCIDENT: **Time of Bite/Incident:** ☐ a.m. ☐ p.m.

Incident Location: Zip Code:

How did the bite occur?

ANIMAL INFO

Animal Name: Animal Type: ☐ Domestic Dog ☐ Domestic Cat ☐ Other:

Size: Breed: Color: Sex: ☐ M ☐ F Age:

If the animal is not at the owner's address where is it located now?

Address: Zip Code:

OWNER

☐ **STRAY** or Animal Owner's Name:

Animal Owner's Address: Zip Code:

Animal Owner's Home Telephone: Cell (Alternate):

PROVIDER INFO

Name of Person Completing this Form: Date Form Completed:

Name of Attending Health Care Provider/Facility:

Phone Number for Health Care Provider:

Notes:

PLEASE FAX COMPLETED REPORT TO 509.324.3603 AS SOON AS POSSIBLE

TO BE COMPLETED BY SRHD: **SRHD BR No.** **Initials:** **Follow-up Date:** **Page** **of**

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