Boston Public Health Commission – Communicable Disease Control Division

Reporting Form for Animal Bites

(Use Research Laboratory Reporting Form if the animal bite was from a research lab animal. Additional reporting forms can be found at www.bphc.org/cdc.)

Fax Completed Form to BPHC-CDC 24 hours a day at (617) 534-5905.
If assistance is needed with animal follow-up, call Boston Animal Control at (617) 635-5349.

I. Exposed Person Information (please print)

Last Name	First Name	Sex ☐M ☐F	Age	D.O.B. ____/____/____

Address	Apt. #	City	State	Zip

Phone	Other Phone	If a minor, Name of Parent or Guardian	Parent/Guardian Phone

II. Exposure Information

Date of Exposure ____/____ /____	Time: AM PM	Location (address)

Animal: ☐ Wild ☐ Domestic	☐ Dog ☐ Cat ☐ Bat ☐ Raccoon ☐Ferret ☐Skunk ☐ Unknown ☐ Other, specify___________	Description (Breed, Color, Sex)

Any pertinent animal testing/vaccination:	Animal Specimen Sent for Rabies Test ☐ Yes, Date ____/____/____ ☐ No ☐ Unknown

Type of Exposure:
- ☐ Bite
- ☐ Scratch
- ☐ Saliva to mucous membrane
- ☐ Other **direct contact** with animal (describe): ____________________
- ☐ Indirect contact with pet/ animal following that animal's exposure to another suspect rabid animal
- ☐ Unknown
- ☐ Other (specify): ____________________

Circumstances surrounding incident: (please describe)

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III. Medical Information

Seen by Medical Provider? ☐ Yes, Date of Visit _____/____/_____ ☐ No ☐ Unknown	Medical record #	Name of Provider

Facility	Phone

Name of Primary Care Provider (PCP)	PCP Facility	Phone

Description of wound (location on body, severity, number, etc.)

IV. Treatment Information

HRIG (Human Rabies Immune Globulin)	☐Yes, Date: ____/____/____ ☐No	Tetanus (Td or Tdap)	☐Yes, Date: ____/____/____ ☐No
Rabies vaccine (HDCV or PCECV)	☐Yes, Date: ____/____/____ ☐No	Previous Post-Exposure or Pre-Exposure Prophylaxis for Rabies	☐Yes, Date: ____/____/____ ☐No

If rabies vaccine series has been initiated, please note facility where subsequent injections will be given. Facility: ______________________________	Other Treatment/Medication:

V. Animal Owner/Facility Information

Last Name	First Name	Phone Number

Address	Apt. #	City	State	Zip

Current Location of Animal (if different from above)	Owner known by victim? ☐ Yes ☐ No ☐ Unknown

VI. Person Completing Form

Name	Phone	Worksite	Date

FAX COMPLETED FORM TO 617-534-5905