Animal Bite Intake Report

Please Fax This Report Within 24 Hours To:
Fax (937) 496-3072

To Be Completed By the Treating Facility

Facility Name: _____ **Physician:** _____

Address _____

City: _____ **Zip Code:** _____

Phone: _____

Rabies Post Exposure Treatment Started Yes ☐ No ☐

Please Complete As Much Information As Possible:

Victim

Date of Injury: _____

Victims Name _____

Victims Address _____

City: _____ **State:** _____ **Zip:** _____

Phone #: (Home): _____ **(Work):** _____ **(Cell):** _____

Sex: M ☐ **F** ☐ **Age:** _____ **Type of Injury: Bite** ☐ **or Scratch** ☐

Location of Injuries on Body: _____

Was Victim Injured On ☐ **or Off** ☐ **the Animal Owners Property**

Name of Parent/Guardian _____

Address (if different from victim) _____ **Phone#** _____

Animal

Animal Type: ☐ **Dog** ☐ **Cat** ☐ **Bat** ☐ **Raccoon** ☐ **Other** _____

Color _____ **Breed** _____ **Name** _____

Location of Animal _____ **Stray:** ☐ **Yes** ☐ **No**

Rabies Tag # _____ **Veterinarian** _____

Owner

Name _____ **Address** _____

City _____ **State** _____ **Zip** _____

Phone # _____