

# Rhode Island Department of Health (RIDOH) – Animal Bite Case Report Form

**RABIES VACCINE AND RABIES IMMUNE GLOBULIN ADMINISTRATION REQUIRES PRE-AUTHORIZATION BY RI DOH PHYSICIAN**

## Patient Information:

Name: Last: \_\_\_\_\_ First: \_\_\_\_\_  Male  Female Age: \_\_\_\_\_ Date of birth: \_\_\_/\_\_\_/\_\_\_\_  
Address: Street: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone number(s): Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_  
Name of additional contact: \_\_\_\_\_ Phone no. of additional contact: \_\_\_\_\_  
Wt (in lbs): \_\_\_\_\_ Insurance (only needed for vaccine recipients):  None  Yes Name of plan: \_\_\_\_\_

## Human Exposure OR Incident Information:

Incident date: \_\_\_/\_\_\_/\_\_\_\_ City/Town of incident: \_\_\_\_\_ Report date: \_\_\_/\_\_\_/\_\_\_\_  
Reported by: \_\_\_\_\_ Phone: \_\_\_\_\_  
Describe incident: \_\_\_\_\_  
\_\_\_\_\_  
*(continue on back)*

## Exposing Animal Information:

Type:  Dog ( Stray  Owned)  Cat ( Stray  Owned)  Bat  Raccoon  Skunk  Other (*specify species*): \_\_\_\_\_  
Status (*check all that apply*):  Captured  Retrievable  Quarantined  Euthanized  Lab Exam  
Location if quarantined: \_\_\_\_\_  
Rabies vaccination status:  UTD  Not UTD  Unknown  Does Not Apply  
Owner (if not victim): \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_

## Wound Information:

Type:  Bite – penetration of the skin by teeth  Scratch  Abrasion  Proximity (bats)  
 Saliva of animal on wound lesions/mucosa  
Location:  Arm  Leg  Head/Neck  Trunk Other (Specify): \_\_\_\_\_

## Lab Exam (animal):

Date of lab result: \_\_\_/\_\_\_/\_\_\_\_ Rabies number: \_\_\_\_\_  
Exam result:  Positive  Negative  Inconclusive  Unable to test Bat Species: \_\_\_\_\_

## Recommendations for Post Exposure Prophylaxis:

Immunosuppressed:  No  Yes Specify condition (contact medical provider as needed): \_\_\_\_\_

- No risk exposure (zero risk): No vaccine recommended
- Low risk exposure: No vaccine recommended
- Rabies exposure: HRIG and 4 doses vaccine released
- Rabies exposure (person immunocompromised): HRIG and 5 doses vaccine released (Titer required 2 weeks after last dose in series)
- Patient refused vaccine (after risk counseling by nurse and/or MD)
- Exposure in person previously vaccinated with an FDA approved vaccine (HDCV or PCEC): 2 doses vaccine released (No HRIG)
- "Off schedule" vaccination (describe): \_\_\_\_\_
- Other vaccination recommendation: \_\_\_\_\_

Dispensing pharmacy: \_\_\_\_\_

Authorizing DOH Physician: \_\_\_\_\_

DOH Nurse/DIS: \_\_\_\_\_

Place and Date of RX

1<sup>st</sup> Dose \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
2<sup>nd</sup> Dose \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
3<sup>rd</sup> Dose \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
4<sup>th</sup> Dose \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
5<sup>th</sup> Dose \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_\_

## Return Form to:

Rhode Island Department of Health,  
Division of Infectious Disease and Epidemiology  
Room 106, 3 Capitol Hill, Providence, RI 02908 **or**  
Fax: (401) 222-2477 **or** Phone: (401) 222 2577, (401)272 5952 after hours