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

RABIES VACCINE AND RABIES IMMUNE GLOBULIN ADMINISTRATION REQUIRES PRE-AUTHORIZATION BY A RIDOH PHYSICIAN

Patient Information:

Name: Last: ______________________ First: ____________________ ☐ Male ☐ Female Age: _____ Date of birth: _____ /_____ /_____

Address: Street: ____ City: _________________________ State: _______ Zip Code: ____________

Phone number(s): Cell: __________________________ Home: ________________________ Work: _________________________________

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Unknown

Name of additional contact**:** _________________________________ Phone no. of additional contact**:** _________________________________

Incident Information:

Incident date: _____ /_____ /______ City of incident: ____________________________ State of incident: ______ Report date: _____ /_____ /______

Reported to RIDOH by (*name & organization*): ____ Phone: _________________________________

Describe incident: ____ *(continue on back)*

Exposing Animal Information:

Type: ☐ Dog ☐ Cat ☐ Bat ☐ Raccoon ☐ Skunk ☐ Other (*specify species*): ______________________

If Dog or Cat: ☐ Owned ☐ Stray ☐ Unknown

Owner: ☐ Victim ☐ Not Victim: *If Not Owned By Victim:* Owner's Last Name: __________________ Owner's First Name: _________________

Owner's Address: ____________________________________ Owner's Phone: ______________________

Status of animal at time of report (*Check ONE*): ☐ Not captured, but known to victim ☐ Quarantined *(location):*_______________ ☐ Dead but NOT tested for rabies ☐ Submitted for Lab Testing ☐ Not captured

Wound Information:

Type: ☐ Bite – penetration of the skin by teeth ☐ Scratch or Abrasion ☐ Saliva of animal on wound/lesions/mucosa ☐ Proximity (bats)

Location: ☐ Arm or Hand ☐ Leg or Foot ☐ Head or Neck ☐Trunk Details: ________________________________

DO NOT WRITE BELOW THIS LINE – RIDOH OFFICIAL USE ONLY:

Lab Exam (*animal*): Date of lab result: _____ /_____ /_____ Rabies number: ______________________________

Exam result: ☐ Positive ☐ Negative ☐ Inconclusive ☐ Unable to test If bat, note species: ___________________________

Final Disposition (*Check ONE*): ☐ Alive and well ☐ Quarantined *(location):*______________________________ ☐ Dead but NOT tested for rabies ☐ Submitted for Lab Testing ☐ Not captured

Rabies vaccination status: ☐ UTD ☐ Not UTD ☐ Unknown ☐ Does Not Apply

Additional Patient Information (*for Vaccine Recipients Only*): Weight (*lbs.*): ______ Insurance: ☐ No ☐ Yes Name of plan: ________________

Immunosuppressed: ☐ No ☐ Yes: Specify condition (*contact medical provider as needed*): ____

Was the patient previously vaccinated against rabies? ☐ No ☐ Yes If yes, when: ____

Recommendations for Post Exposure Prophylaxis:

☐ No risk exposure: Keep record for case management filing – no data entry required [e.g., non-rabies species; neg. test result; assessed as non-exposure]

☐ Low risk exposure: No vaccine recommended (*Check ONE*: ☐ 10 day quarantine ☐ Animal remains alive and well ☐ Lowest risk animal type)

☐ Rabies exposure (*Check ONE)*:

- ☐ HRIG and 4 doses vaccine
- ☐ HRIG and 5 doses vaccine [Person immunocompromised. Titer required 2 weeks after final dose]
- ☐ No HRIG and 2 doses vaccine [Person previously vaccinated with FDA-approved vaccine (HDCV or PCEC)]
- ☐ "Off schedule" vaccination (*describe*): ____
- ☐ Other vaccination recommendation (*describe*):____
- ☐ Patient refused vaccine [after risk counseling by nurse and/or MD]

☐ Unable to reach patient -- No response to letter. Letter sent on (*date*): _____ /_____ /______

Vaccine Release Information: Authorizing DOH physician: _______________________ Dispensing Pharmacy: ___________________________

Place of RX: 1st Dose ____________________________ Date of vaccine release: _____ /_____ /______

Initial RIDOH Intake Completed by (*name*):____________________ Date: ____/____/____ **Case Closed by (*name*):**__________________ Date: ____/____/_____

Return Form to: *Rhode Island Department of Health, Center for Acute Infectious Disease Epidemiology, Room 106, 3 Capitol Hill, Providence, RI 02908 or Fax to (401)-222-2477 or Phone report to (401)-222-2577, (401)-276-8046 after hours*

Revised April 2019

Date	Notes