



ANIMAL BITE/EXPOSURE REPORT

SALEM COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES

110 Fifth Street, Suite 400 – Salem, New Jersey 08079

856-935-7510, ext. 8448 Emergency/After Hours call: 856-769-1955

FAX REPORT TO: 856-935-8483

(Physicians must report bites to the local health dept. within 12 hours of attendance per NJAC 26:4-79)

SCDHHS ID#:

VICTIM	Name of Victim:		Age:	Cell Phone:	
	Name of Parent/Guardian if Victim is a Minor:		Daytime Phone Numbers:		
	Address:		City:	State:	Zip:
	Municipality:	County:	Address and County where incident occurred:		
	Has the victim ever been vaccinated for rabies before?:		<input type="checkbox"/> NO	<input type="checkbox"/> YES	If YES, Date:
List any other pets or persons bitten or exposed:					

INCIDENT	Date and Time of Incident:	Part of Body Bitten or Exposed:	<input type="checkbox"/> Bite	<input type="checkbox"/> Skin Broken	<input type="checkbox"/> Scratch
			<input type="checkbox"/> Bat	<input type="checkbox"/> Saliva/Fluids	<input type="checkbox"/> Other
	Description of how the bite or exposure occurred:				
	Did the Animal have any of the following symptoms: <input type="checkbox"/> Aggressiveness <input type="checkbox"/> Overly Friendly or Fearless <input type="checkbox"/> Choking or Difficulty Swallowing				
	<input type="checkbox"/> Sagging Jaw <input type="checkbox"/> Seizures <input type="checkbox"/> Staggering/wobbling <input type="checkbox"/> Paralysis <input type="checkbox"/> Making unusual crying sounds <input type="checkbox"/> Other:				
Name of any Animal Control Officers Involved:			Phone:		
Name of any Veterinarians or Others Involved:			Phone:		

TREATMENT	Name of any Doctor or Hospital visited or consulted:		Phone:
	Describe Treatment given or recommended: <input type="checkbox"/> Tetanus <input type="checkbox"/> Antibiotics <input type="checkbox"/> Other		
	Was Rabies Post-Exposure Treatment/Prophylaxis started?: <input type="checkbox"/> NO <input type="checkbox"/> YES * (see next line) If YES, Date:		
	*If Yes, the treating Doctor or Hospital/Clinic must send a REPORT OF RABIES POST-EXPOSURE TREATMENT (form CDC-2) to the local Health Department (see fax number above). The form is available at http://www.state.nj.us/health/forms/cdc-2.pdf		

ANIMAL/OWNER INFORMATION	Type of Animal:	Animal is:	<input type="checkbox"/> Victim's Pet	<input type="checkbox"/> Owned by another	<input type="checkbox"/> Unknown
	<input type="checkbox"/> Dog <input type="checkbox"/> Cat <input type="checkbox"/> Bat Other:	<input type="checkbox"/> Wild	<input type="checkbox"/> stray/Feral	<input type="checkbox"/> Livestock	Other:
	Animal Description (Breed, Color, Markings, Sex):				
	Name of Owner:		Cell Phone:	Daytime Numbers:	
	Address:		City:	State:	Zip:
	Municipality:	County:	Animal's Location:		
			<input type="checkbox"/> Owner's Property <input type="checkbox"/> Loose/Unknown <input type="checkbox"/> Vet <input type="checkbox"/> Shelter <input type="checkbox"/> Other :		
	Address where animal is currently located if different from Owner:			Phone:	
	If Euthanized, reason for doing so:		Date:	Location of the body:	
	<input type="checkbox"/> Sick <input type="checkbox"/> Aggressiveness <input type="checkbox"/> Other:				
Is/was the animal current on it's rabies vaccinations?		Date of last shot:	Expiration:		
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown					
Name of Veterinarian:			Phone:		

SCDHHS	Was animal current on rabies vaccination?	Was animal tested for rabies?	Results if tested for rabies:	Was PEP recommended for victim?
	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown	<input type="checkbox"/> Positive/Unsatisfact. <input type="checkbox"/> Negative	<input type="checkbox"/> YES <input type="checkbox"/> NO
	Was confinement ordered?	Type of Confinement/Release Ordered:	<input type="checkbox"/> Verbal (same immediate family/trusted source) <input type="checkbox"/> 45 day w/PSMP	
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> 10 day observation <input type="checkbox"/> 45 day observation <input type="checkbox"/> 4 month standard <input type="checkbox"/> 4 month strict			
Confinement Dates:		Confinement Release Performed:		
Start: _____ End: _____		Date: _____ Inspector Initials: _____		