REPORT OF ANIMAL BITE - POTENTIAL RABIES EXPOSURE

(Please read Privacy Act Statement before completing this form.)

SEQUENCE NUMBER

PRIVACY ACT STATEMENT

This statement serves to inform you of the purpose for collecting your personal information required by the Report of Animal Bite - Potential Rabies Exposure form and how it will be used.

AUTHORITY: 10 U.S.C. 55, Medical and Dental Care; 32 CFR Part 199, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); DoDD 6490.02E, Comprehensive Health Surveillance; DoDI 6015.23, Delivery of Healthcare at Military Treatment Facilities: Foreign Service Care, Third-Party Collection, Beneficiary Counseling and Assistance Coordinators; Office of the Assistant Secretary of Defense Health Affairs, Public Health Shared Service Memo, Oct 31, 2014; and E.O. 9397 (SSN), as amended.

PRINCIPAL PURPOSE(S): To collect information necessary to record the history and assessment of rabies risk to a person who has possibly been exposed to rabies through an animal bite or other route, and to record exam observations, animal laboratory findings, disposition results, and follow-up care for that person.

ROUTINE USE(S): Your records may be disclosed outside of DoD to aid in preventive health and communicable disease control programs and report medical conditions to Federal, state, and local agencies as required by law. Use and disclosure of your records may also occur in accordance with the DoD Blanket Routine Uses published at http://dpcld.defense.gov/Privacy/SORNsIndex/BlanketRoutineUses.aspx and as permitted by the Privacy Act of 1974, as amended (5 U.S.C. 552a(b)).

DISCLOSURE: Voluntary. However, failure to provide all the requested information may result in the improper treatment and care being administered to the patient.

1. PATIENT IDENTIFICATION

a. NAME *(Last, First, Middle Initial)*	b. SEX	c. DATE OF BIRTH *(YYYYMMDD)*	d. RELATIONSHIP TO SPONSOR

e. BENEFICIARY STATUS	f. COMPONENT STATUS	g. DEPARTMENT/SERVICE

h. SPONSOR NAME *(Last, First, Middle Initial)*	i. FAMILY MEMBER PREFIX (FMP)	j. SSN/DoD EIDN	k. RANK/GRADE

l. UNIT	m. WORK PHONE	n. HOME/CELL PHONE	o. EMAIL ADDRESS

PART I - ANIMAL BITE HISTORY *(To be completed by Emergency Department or Primary Care Interviewer)*

2. DESCRIPTION OF ANIMAL

a. TYPE *(Dog, cat, etc.)*	b. BREED	c. SIZE	d. COLOR	e. SEX

3. DATE/TIME OF INCIDENT

a. DATE *(YYYYMMDD)*	b. HOUR

4.a. PRESENT LOCATION OF ANIMAL *(or last known location)* ☐ ON POST ☐ OFF POST ☐ UNKNOWN

b. GEOGRAPHIC ADDRESS WHERE INCIDENT OCCURRED ☐ ON POST ☐ OFF POST ☐ UNKNOWN

5. CIRCUMSTANCES LEADING TO BITE/SCRATCH OR MUCOUS MEMBRANE EXPOSURE *(with potential for contamination by saliva or neural tissue).* Note if the bite or scratch was provoked/could have been provoked or unprovoked (e.g., an unexplained attack).

6. APPARENT HEALTH OF ANIMAL *(Describe abnormal or unusual behavior)* ☐ NORMAL BEHAVIOR ☐ ABNORMAL BEHAVIOR

7. ANIMAL OWNER ☐ *(X if owner unknown)*

a. NAME *(Last, First, Middle Initial)*	b. STATUS *(X one)* ☐ MILITARY ☐ CIVILIAN	c. PHONE NUMBER *(Include Area Code/DSN)*	d. ADDRESS *(Street, City, State, Zip Code)*

8. COMPLETED BY

a. NAME *(Last, First, Middle Initial)*	b. TITLE	

c. SIGNATURE	d. DEPARTMENT/SERVICE/CLINIC	e. DATE PREPARED *(YYYYMMDD)*

PART II - MANAGEMENT OF ANIMAL BITE CASE *(To be completed by Medical Officer (Information from SF 600))*

9. INJURY, LOCATION ON THE BODY, AND WOUND TREATMENT ☐ ANIMAL BITE ☐ CLAW WOUND ☐ OTHER

WOUND TREATMENT PROVIDED? ☐ YES ☐ NO ☐ N/A

DESCRIBE:

10. TETANUS IMMUNIZATION GIVEN?
☐ YES ☐ NOT INDICATED ☐ RECOMMENDED BUT DECLINED

11. HUMAN RABIES VACCINE INITIATED?
☐ YES ☐ NOT INDICATED ☐ RECOMMENDED BUT DECLINED

12. HUMAN RABIES IMMUNOGLOBULIN GIVEN?
☐ YES Site: _____ ☐ NOT INDICATED ☐ RECOMMENDED BUT DECLINED

13. PREVENTIVE MEDICINE/PUBLIC HEALTH CONSULTED?
☐ YES Date: _____ ☐ NO

14. ARMY VETERINARIAN CONSULTED?
☐ YES Date: _____ ☐ NO

15. MEDICAL OFFICER

a. NAME *(Last, First, Middle Initial)*

b. SIGNATURE

PART III - MANAGEMENT OF BITING ANIMAL *(To be completed by Veterinarian)*

16. DATE RECEIVED FROM MTF *(YYYYMMDD)*

17. LOCATION OF ANIMAL DURING OBSERVATION PERIOD
(On or off post, list point of contact if not veterinary activity)
☐ ANIMAL NOT FOUND *(X)*

18. FINDINGS

a. INITIAL EXAMINATION FINDINGS AND DATE

b. RABIES VACCINE INFORMATION AND DATE(S)

19. OBSERVED BY *(Include name of military or civilian agency)*

20. DATES OBSERVED *(YYYYMMDD)*

a. FROM

b. TO

21. END OF QUARANTINE EXAM FINDINGS

22. RESULT OF QUARANTINE *(X one)*
☐ RELEASED FROM QUARANTINE
☐ EUTHANIZED AND SAMPLE SUBMITTED
DATE *(YYYYMMDD)*

23. LABORATORY FINDINGS OF ANIMAL SUBMITTED FOR RABIES DIAGNOSIS

a. TEST *(X one)*	b. DATE RECEIVED *(YYYYMMDD)*	c. RESULTS *(X one)*	
☐ (1) FLUORESCENT ANTIBODY		☐ NEGATIVE	☐ POSITIVE
☐ (2) CELL CULTURE		☐ NEGATIVE	☐ POSITIVE

24. VETERINARY OFFICER

a. NAME *(Last, First, Middle Initial)*	b. SIGNATURE	c. DATE SIGNED *(YYYYMMDD)*

PART IV - CASE REVIEW *(To be completed by Preventive Medicine/Public Health Officer)*

25. RABIES ADVISORY BOARD a. DATE CASE REVIEWED *(YYYYMMDD)* _____ ☐ NOT REQUIRED

b. COMMENTS *(e.g., risk assessment, vaccine series completion, serology (if conducted), etc.)*:

26. PREVENTIVE MEDICINE PHYSICIAN or DESIGNATED HEALTHCARE PROVIDER

a. NAME *(Last, First, Middle Initial)*	b. SIGNATURE	c. DATE SIGNED *(YYYYMMDD)*