



Date: _____

Animal Bite Investigation Form

Client Information

⇒format all dates as: year/month/day (yyyy/mm/dd)

Victim's Name:		<input type="checkbox"/> Male	DOB : ____ / ____ / ____
PHN:		<input type="checkbox"/> Female	Age: _____
Parent/Guardian (if victim is a minor):			Phone Number H: _____ W: _____
Mailing Address:	Postal Code:	First Nation:	
Attending Physician or Primary Care Nurse:	Attending Physician/Nurse Phone #:	Date first attended by Physician: ____ / ____ / ____	
Previously immunized for Rabies: Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/>	If yes, date rabies immunization completed: ____ / ____ / ____		
Primary Tetanus Series completed : Yes <input type="checkbox"/> No <input type="checkbox"/>	Date of last Tetanus Vaccine : ____ / ____ / ____		

Incident & Initial Assessment

Date of Exposure: ____ / ____ / ____	Unique Animal ID Number: _____
Place of Exposure: Name of town/city/ (if within city limits)- _____ OR	
RM (rural): _____ OR First Nations Community: _____	
Type of Exposure ¹ : Bite <input type="checkbox"/> Puncture wound <input type="checkbox"/> Scratch <input type="checkbox"/> Saliva on intact skin <input type="checkbox"/> Saliva on existing lesion <input type="checkbox"/> Saliva on mucous membranes <input type="checkbox"/> Occupational - Bite <input type="checkbox"/> Occupational - Scratch <input type="checkbox"/> Occupational - Saliva on intact skin <input type="checkbox"/> Occupational - Saliva on existing lesion <input type="checkbox"/> Occupational - Saliva on mucous membranes <input type="checkbox"/>	
No known contact <input type="checkbox"/> Other <input type="checkbox"/> , specify _____	
Type of attack: Provoked <input type="checkbox"/> Unprovoked <input type="checkbox"/> Unknown <input type="checkbox"/>	
Wound Location: Head/Neck <input type="checkbox"/> Face <input type="checkbox"/> Arm <input type="checkbox"/> Hand/Finger <input type="checkbox"/> Torso <input type="checkbox"/> Leg <input type="checkbox"/> Foot/Toe <input type="checkbox"/> Mucosa <input type="checkbox"/> Unknown <input type="checkbox"/> Other <input type="checkbox"/> , specify _____	
Animal Species: Dog <input type="checkbox"/> Cat <input type="checkbox"/> Bat <input type="checkbox"/> Cow <input type="checkbox"/> Horse <input type="checkbox"/> Skunk <input type="checkbox"/> Raccoon <input type="checkbox"/> Hog <input type="checkbox"/> Fox <input type="checkbox"/> Other <input type="checkbox"/> , specify _____	
Animal Type: Pet (indoor) <input type="checkbox"/> Pet(outdoor) <input type="checkbox"/> Pet(Indoor/Outdoor) <input type="checkbox"/> Outdoor Farm Animal <input type="checkbox"/> Wild <input type="checkbox"/> Stray <input type="checkbox"/> Unknown <input type="checkbox"/>	
Animal Description (size//breed/color): _____ Male <input type="checkbox"/> Female <input type="checkbox"/> Animal Spayed /Neutered No <input type="checkbox"/> Yes <input type="checkbox"/>	
Animal healthy at time of incident: Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/>	
Symptoms: _____	
History of Incident/Exposure:	

¹ Occupational exposures are when the person is exposed through performing job duties (i.e. a mail carrier bitten would not be an occupational exposure, however a veterinarian handling a sick animal would be).

Animal Vaccinated: No Unknown Yes , please provide details/dates:

Veterinarian:

Vet Phone number:

Owner Name:

Address:

Home Phone #

Work Phone#

Animal Observation	Date	Inspected by:	Observation comments
First Inspection on Day 1			
Second Inspection on Day 5 (in case where bite to head region)			
Last inspection on day 10 ²			

Animal Retention Result: Became Ill Released Natural Death Destroyed Escaped

Brain Sent for Testing? Yes Date sent: ____/____/____ No Why not? _____

Primary Lab Results: Positive Negative

Final Lab Results: Positive Negative

Tetanus Recommendation: Indicated? Yes No

Administered? Yes Date: ____/____/____ No Why not?

Rabies Immune Globulin & HDCV Recommendation:

Recommended Not recommended Unknown at this time if recommended, complete immunization record (below)

Date received: ____/____/____

Date MHO Review: ____/____/____

Date sent to CFIA: ____/____/____

Immunization Information

RIG Dosage: Weight in kg = ____ × 20 IU / kg = ____ IU (2 mL vial contains 300 IU = 150 IU/mL) = ____ mL

Date: ____/____/____

Site(s)/Amount (ml) _____ Administered by: _____

Vaccine (HDCV): Lot #/Expiry Date	Series	Date	Administered by	If series not completed, why not? <input type="checkbox"/> Animal well after observation period <input type="checkbox"/> Animal results negative <input type="checkbox"/> Victim previously immunized <input type="checkbox"/> Victim refused further doses <input type="checkbox"/> Lost to follow-up <input type="checkbox"/> Referred out of province <input type="checkbox"/> Other _____
	1 st Dose	____/____/____	_____	
	Day 3	____/____/____	_____	
	Day 7	____/____/____	_____	
	Day 14	____/____/____	_____	
	Day 28 ³	____/____/____	_____	

Remarks (e.g. vaccine reactions):

MHO or Designate Signature:

Date:

Please return the completed form to Northern Inter Tribal Health Authority @ Fax: (306) 953 - 5020.

² Check on animal condition on day 9 and day 11 if day 10 falls on weekend or statutory holiday

³ Only required for immunocompromised individuals