

**Animal Exposure Case Report -- Human Patients Only**  
(Confidential)

**Philadelphia Department of Public Health  
Division of Disease Control**

Communicable Disease Control Program  
500 S. Broad Street, Philadelphia, PA. 19146



**Identification of Human Patient**

Report Date (Mo., Day, Yr.) 		Name (Last, First, M.I.)		Parent or Caretaker (if applicable)	
Address (Number, Street, Apt #, City, Zip Code)				Telephone (H) _____ (W) _____ (C) _____	
DOB (Mo., Day, Yr.) 	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Occupation		
Name of Employer or School			Address ( Number, Street, City, Zip Code)		

**Medical Information**

Type of Exposure <input type="checkbox"/> Bite <input type="checkbox"/> Scratch <input type="checkbox"/> Other _____		Date Bite Occurred (Mo., Day, Yr.) 	Treatment Received? <input type="checkbox"/> Tetanus vaccine <input type="checkbox"/> No treatment <input type="checkbox"/> Antibiotics <input type="checkbox"/> Unknown <input type="checkbox"/> Rabies treatment		Fatal (check one) <input type="checkbox"/> Yes <input type="checkbox"/> No
Part of Body Bitten	If Case Hospitalized (Name of Hospital)		Admission Date 	Discharge Date 	

**Circumstances Surrounding Animal Exposure**

**Animal Information**

Type of Animal (dog, cat, bat, raccoon, etc.)	Breed of Animal	Color of Animal	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Spayed/Neutered? <input type="checkbox"/> Yes <input type="checkbox"/> No	Age of Animal
Indicate Whether the Animal Exhibited Any of the Following Symptoms: <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Unusual Viciousness <input type="checkbox"/> Sagging Jaw <input type="checkbox"/> Slobbering <input type="checkbox"/> Choking <input type="checkbox"/> No unusual symptoms			Animal Belongs to Patient's Household? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		County Where Animal Bite Occurred
Current Location of Animal (Check one) <input type="checkbox"/> Owner <input type="checkbox"/> PACCA for Observation <input type="checkbox"/> Unknown/No Follow-up Address <input type="checkbox"/> PACCA Submitting for Rabies Test <input type="checkbox"/> Stray <input type="checkbox"/> Veterinarian Submitting for Rabies Test			PACCA/Institute Animal ID#	Animal Rabies Vaccine Current? <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes (Date Vaccinated ___ \ ___ \ ___)	
Name of Owner	Address of Owner (Number, Street, City, Zip Code)			Telephone	

**Reporter Information**

Name of Person Reporting Case	Reporter <input type="checkbox"/> ICP <input type="checkbox"/> Veterinarian <input type="checkbox"/> ED <input type="checkbox"/> PACCA Other _____	Telephone
Reporting Institution	Address (Number, Street, City, Zip Code)	

**DO NOT WRITE IN AREA BELOW - FOR DEPARTMENT USE**

Name (Person Receiving Report)	Method of reporting <input type="checkbox"/> Telephone <input type="checkbox"/> Fax <input type="checkbox"/> Mail <input type="checkbox"/> Active Surveillance <input type="checkbox"/> Other _____
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**Any unusual illness, disease clusters or possible outbreaks should be reported *immediately* by telephone.  
Please fax all completed reports to 215-545-8362, or call 215-685-6748 to report a case by telephone.**