PLEASE PRINT CLEARLY

NORTHERN NEVADA Public Health | Epidemiology & Public Health Preparedness

FAX COMPLETED REPORTS TO: (775) 328-3764

ANIMAL BITE REPORT – To Be Completed By Health Care Provider

INSTRUCTIONS FOR COMPLETING FORM:	**This form should be completed by the health care provider, unless the person bitten did not seek medical care.** Complete all sections in full. **Fax completed form as soon as possible to Northern Nevada Public Health (NNPH) at 328-3764.** This allows the local rabies control authority to evaluate & monitor the biting animal and fulfills the health care provider's requirement to report animal bites under Nevada Administrative Code 441A. The original form should stay with the patient's chart. Questions? Call 328-2447.

Today's Date: _____ **Name of Hospital/ Urgent Care/Clinic:** _____

Exposed Person

Age: _____ ☐ Months ☐ Years

Name: _____ Date of Birth: _____

Parent/Guardian's Name if patient is a minor: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone: Home: _____ Work: _____ Cell: _____

Bite

Date of Bite: _____ Time _____ ☐ AM ☐ PM

Where on body bitten? _____ Skin Broken? ☐ Yes ☐ No

☐ **If bite occurred at exposed person's address, check this box and skip to Animal Information. If not, complete the following:** Address/place where bite occurred: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Animal Information

Species: ☐ Dog ☐ Cat ☐ Ferret ☐ Other: _____

Age: _____ Breed: _____ Color: _____ Name of Animal (if known) _____

Owner's Name: _____

☐ **If owner is exposed person, check this box & skip to Medical care obtained. If not, complete the following:**

Street Address: _____ City: _____ Zip: _____

Phone: Home: _____ Work: _____ Cell: _____

Medical care obtained? ☐ Yes ☐ No If yes, complete the following:

Health care provider: _____ Hospital/Urgent Care/Clinic: _____

Explain circumstances of bite incident: _____

This information is accurate to the best of my knowledge.

Signature of Person Bitten or Parent/Guardian: _____