pennsylvania
DEPARTMENT OF HEALTH

Human Exposure Rabies Questionnaire

(http://www.dsf.health.state.pa.us/health/lib/health/labs/rabies_form_2006.pdf)

HR 102.71 (18 Mar 08)

Submit Completed Form together with Animal Specimen To:

Bureau of Laboratories
110 Pickering Way
Exton, PA 19341
Phone: (610) 280-3464
FAX: (610) 524-2079

(Bureau of Labs Use ONLY)

Submitter Specimen Reference ID (*if any*): _____ **Date of Death:** ____ / ____ / ____ **Type of Death:** ☐ Natural ☐ Destroyed

Kind of Animal Submitted (*Specify*): _____

Indicate whether the animal exhibited any of the following symptoms. Check all that apply.

☐ Difficulty Swallowing ☐ Loss of Appetite ☐ Unusual Viciousness ☐ Straining ☐ Choking ☐ Wandering from Home ☐ Slobbering ☐ Restlessness & Excitability ☐ Sagging Jaw ☐ Paralysis in Hind Legs

Human Exposure? ☐ **Other Animal Exposure?** ☐ **County Where incident occurred:** _____

Please provide any additional information regarding the behavior of the animal and circumstances of exposure:

Was the submitted animal vaccinated against Rabies? ☐ **YES** ☐ **NO** ☐ **UNKNOWN**

If the answer is '**YES**', please provide the date of the LAST vaccination: **Date:** ____ / ____ / ____

Person Bitten or Scratched:

☐ If multiple victims were involved, enter the number of persons exposed here. Attach additional sheets for each victim.

NAME (Last, First): _____ Phone: (____) ____ - ____

Street Address: _____

City, State, Zip: _____ County: _____

Area of Body Bitten: _____ Scratched: _____ Date: ____ / ____ / ____

Owner of Submitted Animal: (If wildlife use Pennsylvania Game Commission (PGC) contact information)

NAME (Last, First): _____ Phone: (____) ____ - ____

Street Address: _____

City, State, Zip: _____ County: _____

NOTE: Results will only be reported by telephone to the Veterinarian, Physician or Health Facility. Phone No. MUST be provided.

VETERINARIAN/SUBMITTER Name & Address:

Name: _____

Address: _____

Phone: (____) ____ - ____ ext. ____

FAX: (____) ____ - ____

Email: _____

If the victim consulted a PHYSICIAN or HEALTH CARE FACILITY, please provide Name & contact information:

Name: _____

Address: _____

Phone: (____) ____ - ____ ext. ____

FAX: (____) ____ - ____

Email: _____

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RESULTS: Codes:

Contact: _____

Facility: _____

Phone: _____ Date: ____ / ____ / ____

Contact Tech Initials: _____ Report Reviewed ☐ Initials: _____

Review Date: ____ / ____ / ____

Contact: _____

Facility: _____

Phone: _____ Date: ____ / ____ / ____

Contact Tech Initials: _____ Report Reviewed ☐ Initials: _____

Review Date: ____ / ____ / ____

Contact: _____

Facility: _____

Phone: _____ Date: ____ / ____ / ____

Contact Tech Initials: _____ Report Reviewed ☐ Initials: _____

Review Date: ____ / ____ / ____

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