

ANIMAL BITE REPORT FORM



Kentucky Department for Public Health
275 East Main Str. HS2GWC
Frankfort, KY 40621

EPID 270 – 8/2019



KentuckyPublicHealth
Prevent. Promote. Protect.

Patient Information

Name:		Date of Birth:
Current address:		
City:	State:	ZIP Code:
Home Phone:	Cell Phone:	Emergency Contact:

Incident/Exposure Information

Date of incident:	Time: <input type="checkbox"/> am / <input type="checkbox"/> pm
Address Where Bite Occurred:	
Animal: <input type="checkbox"/> Wild <input type="checkbox"/> Domestic	<input type="checkbox"/> Dog <input type="checkbox"/> Bat <input type="checkbox"/> Raccoon <input type="checkbox"/> Unknown <input type="checkbox"/> Cat <input type="checkbox"/> Skunk <input type="checkbox"/> Other, specify: _____
Animal Breed:	Animal Sex & Mark if Sterilized: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Sterilized
Animal Color:	
Location of Bite (Head/facial or body):	

Animal Information

Owner Name:	Date of Birth:	Driver License #:
Address:		
City:	State:	ZIP Code:
Phone:		
Animal Name:		

Medical/Treatment Information

Seen by Medical Provider? <input type="checkbox"/> Yes, Date of Visit: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown	Name of Provider:
Facility:	Phone:
Did the patient receive treatment: <input type="checkbox"/> No <input type="checkbox"/> Yes (Please indicate type of treatment(s) below)	
Rabies Immunoglobulin (RIG): <input type="checkbox"/> No <input type="checkbox"/> Yes, _____ IU (20 IU/kg)	Rabies Vaccine: <input type="checkbox"/> No <input type="checkbox"/> Yes
TD given: <input type="checkbox"/> No <input type="checkbox"/> Yes Date of last Tetanus: _____	Antibiotics:

Reporting Provider Information

Name:	Phone Number:	Worksite Location:	Date:
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Kentucky Revised Statute (KRS) 258.065 requires reporting of animal bites by a provider within 12 hours/or next business day, of initial assessment.
FAX to your local Health Department