

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**

<b>INSTRUCTIONS FOR COMPLETING FORM:</b>	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.
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<b>Today's Date:</b> _____	<b>Name of Hospital/ Urgent Care/Clinic:</b> _____
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<b>Exposed Person</b>	Name: _____	Age: _____ <input type="checkbox"/> Months <input type="checkbox"/> Years
	Parent/Guardian's Name if patient is a minor: _____	Date of Birth: _____
	Street Address: _____	City: _____ State: _____ Zip: _____
	Phone: Home: _____	Work: _____ Cell: _____

<b>Bite</b>	Date of Bite: _____	Time _____ <input type="checkbox"/> AM <input type="checkbox"/> PM
	Where on body bitten? _____	Skin Broken? <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> <b>If bite occurred at exposed person's address, check this box and skip to Animal Information. If not, complete the following:</b>	
	Address/place where bite occurred: _____	
	Street Address: _____	City: _____ State: _____ Zip: _____

<b>Animal Information</b>	Species: <input type="checkbox"/> Dog <input type="checkbox"/> Cat <input type="checkbox"/> Ferret <input type="checkbox"/> Other: _____
	Age: _____ Breed: _____ Color: _____ Name of Animal (if known) _____
	Owner's Name: _____
	<input type="checkbox"/> <b>If owner is exposed person, check this box &amp; skip to Medical care obtained. If not, complete the following:</b>
	Street Address: _____ City: _____ Zip: _____
	Phone: Home: _____ Work: _____ Cell: _____

<b>Medical care obtained?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, complete the following:
	Health care provider: _____	Hospital/Urgent Care/Clinic: _____

<b>Explain circumstances of bite incident:</b>	_____
	_____
	_____

This information is accurate to the best of my knowledge.

**Signature of Person Bitten or Parent/Guardian:** \_\_\_\_\_