



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
ANIMAL BITE/POSSIBLE HUMAN EXPOSURE TO RABIES
SUPPLEMENTAL CASE REPORT

MOHSIS ID NUMBER

EXPOSED PERSON INFORMATION

NAME OF PERSON EXPOSED "CASE" (LAST, FIRST, MI)		DATE OF BIRTH / /	AGE	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
RACE <input type="checkbox"/> WHITE <input type="checkbox"/> BLACK <input type="checkbox"/> AMERICAN INDIAN/ALASKAN NATIVE <input type="checkbox"/> ASIAN <input type="checkbox"/> PACIFIC ISLANDER <input type="checkbox"/> NOT SPECIFIED		HISPANIC <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN		
STREET ADDRESS "CASE"		CITY	COUNTY	STATE
DATE OF BITE/EXPOSURE / /	TELEPHONE NUMBER "CASE"	2ND TELEPHONE NUMBER "CASE" (EX. CELL, WORK)		

REPORTER/HEALTH CARE PROVIDER INFORMATION

NAME OF PERSON REPORTING BITE/EXPOSURE		REPORTER'S RELATIONSHIP TO "CASE"	REPORTER TELEPHONE NUMBER
DID "CASE" SEEK MEDICAL CARE? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK	NAME HEALTH CARE PROVIDER	HOSPITAL/CLINIC NAME	TELEPHONE NUMBER

RABIES POST-EXPOSURE PROPHYLAXIS INFORMATION

DID THE HEALTH CARE PROVIDER OR LPHA GIVE INFORMATION TO THE CASE (OR GUARDIAN) ABOUT RABIES RISK? <input type="checkbox"/> YES <input type="checkbox"/> NO	WAS RABIES POST-EXPOSURE PROPHYLAXIS (RPEP) STARTED? <input type="checkbox"/> YES <input type="checkbox"/> NO DATE STARTED: ___/___/___
NATURE OF EXPOSURE <input type="checkbox"/> BITE <input type="checkbox"/> SALIVA TO MUCOUS MEMBRANE <input type="checkbox"/> CLAW SCRATCH <input type="checkbox"/> OTHER (SPECIFY) _____	
DESCRIPTION OF WOUND (LOCATION ON THE BODY, SEVERITY, NUMBER OF BITES, ETC.) _____ _____	
CIRCUMSTANCES SURROUNDING BITE/EXPOSURE (DESCRIBE IN DETAIL HOW BITE/EXPOSURE OCCURRED) _____ _____	

ANIMAL/ANIMAL OWNER INFORMATION

NAME OF ANIMAL OWNER (IF APPLICABLE)		OWNER'S TELEPHONE NUMBER	OWNER'S RELATIONSHIP TO "CASE"
STREET ADDRESS "ANIMAL OWNER"		CITY	COUNTY
		STATE	ZIP CODE
ANIMAL TYPE (EX. DOG, CAT, BAT)	DESCRIPTION (EX. BREED, AGE, GENDER, SPAYED/NEUTERED, COLOR)	CURRENT LOCATION OF ANIMAL	
PRESENT HEALTH OF ANIMAL	HISTORY OF ANY POTENTIALLY ZOO NOTIC DISEASE (E.G. BRUCELLOSIS)? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK IF YES, SPECIFY: _____		
IS THE ANIMAL'S RABIES VACCINATION CURRENT (IF APPLICABLE) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK	DATE OF LAST RABIES VACCINATION ___/___/___	DURATION OF VACCINE (YEARS)	

VETERINARIAN/QUARANTINE/LABORATORY INFORMATION

NAME OF VACCINATING VETERINARIAN	VETERINARIAN CITY, STATE	VETERINARIAN TELEPHONE NUMBER
IF A PET, DESCRIBE HOW IT IS NORMALLY CONFINED (I.E., HOUSE PET, CONFINED TO YARD, RUNS LOOSE, ETC.) _____		
IS THERE A CITY/COUNTY ANIMAL CONTROL AGENCY THAT CAN LOCATE AND QUARANTINE THE ANIMAL (WHEN APPLICABLE)? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, SPECIFY: _____		

QUARANTINE OF ANIMAL (APPLICABLE ONLY TO DOGS, CATS AND FERRETS)

WAS THE ANIMAL QUARANTINED IN A MANNER APPROVED BY LOCAL ANIMAL CONTROL AUTHORITY? <input type="checkbox"/> YES <input type="checkbox"/> NO	
IF "NO" WHY? <input type="checkbox"/> STRAY ANIMAL, NOT LOCATED <input type="checkbox"/> ANIMAL EUTHANIZED <input type="checkbox"/> ANIMAL NOT A DOG, CAT OR FERRET <input type="checkbox"/> OTHER (SPECIFY) _____	
WAS A SPECIMEN FROM THE ANIMAL SUBMITTED TO SPHL FOR RABIES TESTING? <input type="checkbox"/> YES <input type="checkbox"/> NO	
IF YES, PROVIDE THE NAME, TITLE AND AGENCY OF THE SUBMITTER _____	
INVESTIGATOR, TITLE	DATE ___/___/___