CENTRAL NEVADA HEALTH DISTRICT

PLEASE PRINT CLEARLY

FAX COMPLETED REPORTS TO:
(877) 513-3442

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 the Central Nevada Health District at (877) 513-3442.** 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 (775) 866-7535.

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:

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This information is accurate to the best of my knowledge.
Signature of Person Bitten or Parent/Guardian: ________________