Government of Saskatchewan
Ministry of Health

Animal Bite Investigation Form

Shaded areas are mandatory for reporting to Saskatchewan Ministry of Health

[Indicates field in iPHIS]

Please use yyyy/mm/dd for all dates

Date: _____

Client Information

Victim's Name:		☐ Male ☐ Female	DOB: Age:
PHN:			
Parent/Guardian (if victim is a minor):		Phone number: H: W:	
Mailing Address:	Postal Code:	First Nation:	
Attending Physician or Primary Care Nurse:	Attending Physician/Nurse Phone number:	Date first attended by Physician:	
Previously immunized for Rabies: Yes ☐ Unknown ☐ No ☐	Date immunization completed:		

Incident & Initial Assessment

Date of Exposure:	Unique Animal ID Number:[1]
Place of Exposure: Name of town/city (if within city limits) **OR** RM (rural) **OR** First Nations Community:	
Type of Exposure:[2] Bite ☐ Scratch ☐ Saliva on intact skin ☐ Saliva on existing lesion ☐ Saliva on mucous membranes ☐ Occupational - Bite ☐ Occupational - Scratch ☐ Occupational - Saliva on intact skin ☐ Occupational - Saliva on existing lesion ☐ Occupational - Saliva on mucous membranes ☐ No known contact ☐ Other ☐, specify:	
Type of attack: Provoked ☐ Unprovoked ☐ Unknown ☐	
Wound Location: Head/Neck ☐ Face ☐ Arm ☐ Hand/Finger ☐ Torso ☐ Leg ☐ Foot/Toe ☐ Mucosa ☐ Unknown ☐ Other ☐, specify:	
Animal Species: Dog ☐ Cat ☐ Bat ☐ Cow ☐ Horse ☐ Skunk ☐ Racoon ☐ Hog ☐ Fox ☐ Other ☐, specify:	
Animal Type: Pet (indoor) ☐ Pet(outdoor) ☐ Pet(indoor/outdoor) ☐ Outdoor Farm Animal ☐ Wild ☐ Stray ☐ Unknown ☐ Animal healthy at time of incident: Yes ☐ Unknown ☐ No ☐	
Symptoms:	
History of Incident/Exposure:	

[1] This is a unique animal identifier that should be used in each case report on iPHIS that involves the same animal in the following format: *<health region 3-4 letter acronym>-<four digit calendar year>-<R to indicate Rabies>-<three digit sequential number beginning at 001> (e.g. SCHR-2007-R-001.* This is to be documented in iPHIS in the "Animal Services Incident Number" field.

[2] Occupational exposures are when the person is exposed through performing job duties (i.e. a mail carrier bitten would not be an occupational exposure, however a veterinarian handling a sick animal would be).

Animal Vaccinated: No ☐ Unknown ☐ Yes ☐, please provide details/dates:		
Veterinarian:		Vet Phone number:
Owner Name:	Address:	Phone Number H: W:
Observation Following Exposure: No ☐ Yes ☐ Where?		Date Observation Completed:
Animal Retention Result: Became ill ☐ Released ☐ Natural death ☐ Destroyed ☐ Escaped ☐		
Brain Sent for Testing? Yes ☐ Date sent:	No ☐ Why not?	
Primary Lab Results: Positive ☐ Negative ☐ Final Lab Results: Positive ☐ Negative ☐		

Immunization Recommendation

Tetanus Indicated? Yes ☐ No ☐ Administered? Yes ☐ Date: No ☐ Why not?
Rabies Immune Globulin & Vaccine: Recommended ☐ Not recommended ☐ Unknown at this time ☐ If recommended, complete immunization record (below)

Date received:	Date MHO Review:	Date sent to CFIA:

Immunization Information

RIG Dosage: Weight in kg = _____ × 20 IU / kg = _____ I U (2 mL vial contains 300 IU = 150 IU/mL)
= _____ mL

Date:	Site(s)/Amount (ml)	Administered by:

Prior to initiation of Rabies Post Exposure Prophylaxis, all persons must be screened for immunosuppressive disorders which may include: • Asplenia; • Congenital immunodeficiencies involving any part of the immune system; • Human immunodeficiency virus infection (HIV); • Immunosuppressive therapy; • Haematopoietic stem cell transplant (HSCT) recipient; • Islet cell transplant (candidate or recipient); • Solid organ transplant (candidate or recipient); • Chronic kidney disease; • Chronic liver disease including hepatitis B and C; and • Malignant neoplasms including leukemia and lymphoma. (http://www.ehealthsask.ca/services/manuals/Documents/sim-chapter7.pdf). **Consultation with the MHO should be done in case of any significant illness or for clarification if a candidate for rabies vaccine may be immunosuppressed due to the clinical condition or therapy.**

Vaccine	Series	Date	Administered by	
	1st Dose			If series not completed, why not? ☐ Animal well after observation period ☐ Animal results negative ☐ Victim previously immunized ☐ Victim refused further doses ☐ Lost to follow-up ☐ Referred out of province ☐ Other
	Day 3			
	Day 7			
	Day 14			
	Day 28*			
Remarks (e.g. vaccine reactions):				

*Only required for immunocompromised individuals

RETURN COMPLETED FORM TO REGIONAL MHO

Health Region/Authority: _____

Reported by: _____

Job Designation: _____

Phone: _____ **Fax:** _____

MHO or Designate Signature: _____ Date: _____