

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:		<input type="checkbox"/> Male	DOB:
PHN:		<input type="checkbox"/> Female	Age:
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 <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/>	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 <input type="checkbox"/> Scratch <input type="checkbox"/> Saliva on intact skin <input type="checkbox"/> Saliva on existing lesion <input type="checkbox"/> Saliva on mucous membranes <input type="checkbox"/> Occupational - Bite <input type="checkbox"/> Occupational - Scratch <input type="checkbox"/> Occupational - Saliva on intact skin <input type="checkbox"/> Occupational - Saliva on existing lesion <input type="checkbox"/> Occupational - Saliva on mucous membranes <input type="checkbox"/> No known contact <input type="checkbox"/> Other <input type="checkbox"/> , specify:	
Type of attack: Provoked <input type="checkbox"/> Unprovoked <input type="checkbox"/> Unknown <input type="checkbox"/>	
Wound Location: Head/Neck <input type="checkbox"/> Face <input type="checkbox"/> Arm <input type="checkbox"/> Hand/Finger <input type="checkbox"/> Torso <input type="checkbox"/> Leg <input type="checkbox"/> Foot/Toe <input type="checkbox"/> Mucosa <input type="checkbox"/> Unknown <input type="checkbox"/> Other <input type="checkbox"/> , specify:	
Animal Species: Dog <input type="checkbox"/> Cat <input type="checkbox"/> Bat <input type="checkbox"/> Cow <input type="checkbox"/> Horse <input type="checkbox"/> Skunk <input type="checkbox"/> Raccoon <input type="checkbox"/> Hog <input type="checkbox"/> Fox <input type="checkbox"/> Other <input type="checkbox"/> , specify:	
Animal Type: Pet (indoor) <input type="checkbox"/> Pet (outdoor) <input type="checkbox"/> Pet (indoor/outdoor) <input type="checkbox"/> Outdoor Farm Animal <input type="checkbox"/> Wild <input type="checkbox"/> Stray <input type="checkbox"/> Unknown <input type="checkbox"/> Animal healthy at time of incident: Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/>	
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 <input type="checkbox"/> Unknown <input type="checkbox"/> Yes <input type="checkbox"/> , please provide details/dates:		
Veterinarian:		Vet Phone number:
Owner Name:	Address:	Phone Number H: W:
Observation Following Exposure: No <input type="checkbox"/> Yes <input type="checkbox"/> Where?		Date Observation Completed:
Animal Retention Result: Became ill <input type="checkbox"/> Released <input type="checkbox"/> Natural death <input type="checkbox"/> Destroyed <input type="checkbox"/> Escaped <input type="checkbox"/>		
Brain Sent for Testing? Yes <input type="checkbox"/> Date sent: _____ No <input type="checkbox"/> Why not?		
Primary Lab Results: Positive <input type="checkbox"/> Negative <input type="checkbox"/> Final Lab Results: Positive <input type="checkbox"/> Negative <input type="checkbox"/>		

Immunization Recommendation

Tetanus Indicated? Yes <input type="checkbox"/> No <input type="checkbox"/>
Administered? Yes <input type="checkbox"/> Date: _____ No <input type="checkbox"/> Why not?
Rabies Immune Globulin & Vaccine:
Recommended <input type="checkbox"/> Not recommended <input type="checkbox"/> Unknown at this time <input type="checkbox"/> If recommended, complete immunization record (below)

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

RIG Dosage: $\frac{[20 \text{ IU/kg} \times \text{Weight in kg}]}{[\text{vaccine IU concentration/mL}]}$ = _____ mL

Date:	Site(s)/Amount (ml)	Administered by:
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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	If series not completed, why not?
	1 st Dose			<input type="checkbox"/> Animal well after observation period <input type="checkbox"/> Animal results negative <input type="checkbox"/> Victim previously immunized <input type="checkbox"/> Victim refused further doses <input type="checkbox"/> Lost to follow-up <input type="checkbox"/> Referred out of province <input type="checkbox"/> 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: _____