



ANIMAL EXPOSURE REPORT TO TIMISKAMING HEALTH UNIT

Name of Reporting Health Care Facility _____

CLIENT NAME _____ D.O.B. _____

Male Female Client Phone# _____

Client Address _____

Location of the bite on the client's body _____

Location of Incident _____ Date of Incident _____

Physicians Name _____ Physicians Phone# _____

ANIMAL OWNER INFORMATION (If Known) Name _____

Phone # _____ Address _____

SPECIES

- | | |
|--|-------------------------------------|
| <input type="checkbox"/> Bat | <input type="checkbox"/> Coyote |
| <input type="checkbox"/> Cat, domestic | <input type="checkbox"/> Cat, stray |
| <input type="checkbox"/> Dog, domestic | <input type="checkbox"/> Dog, stray |
| <input type="checkbox"/> Ferret | <input type="checkbox"/> Fox |
| <input type="checkbox"/> Livestock | <input type="checkbox"/> Skunk |
| <input type="checkbox"/> Raccoon | <input type="checkbox"/> Rodents |
| <input type="checkbox"/> Other | <input type="checkbox"/> Unknown |

TYPE OF EXPOSURE

- Bite (broke the skin)
- Mucous membrane exposed
- Open wound
- Scratch
- Other
- Unknown

IF POST-EXPOSURE-PROPHYLAXIS HAS BEEN STARTED, PLEASE COMPLETE THE FOLLOWING`

Date & Provider:	
Client weight: <input type="checkbox"/> kg <input type="checkbox"/> lbs	
Agent: Rabies Immune Globulin	Agent: Rabies Vaccine inactivated
Dose:	Dose:
Lot Number(s)	Lot Number(s)
Expiry Date(s)	Expiry Date(s)
Site of Injection:	Site of Injection:

NOTE: PLEASE FAX FORM TO TIMISKAMING HEALTH UNIT

Confidential Fax # 705-647-5779

If incident occurs after hours, on a weekend or a statutory holiday,
please call our **after-hours number (705) 647-3033**