Onondaga County Health Department

J. Ryan McMahon, II, County Executive
Kathryn Anderson, MD, PhD, MSPH, Commissioner of Health

4170 Route 31, Clay, NY 13041

Division of Environmental Health
Jeffrey Till, Director

Animal Disease Prevention
(315) 435-3165 • fax (315) 435-1651

Suspect Rabies Report

To be completed by medical personnel and faxed to 315-435-1651

Rabies is a fatal disease. Biting animals must be tested or quarantined for 10 days and examined. **This report must be sent to Animal Disease Prevention within 72 hours of the incident.**

Date and time of animal exposure:

Date: _____ **Time:** _____

Animal Description: (dog, cat, name, breed, etc.)

_____

CLINICAL GUIDANCE:
Refer to Rabies Post Exposure Prophylaxis (RPEP)1 Algorithm at health.ny.gov/publications/3028.pdf and NYSDOH Rabies Policies and Procedures at health.ny.gov/diseases/communicable/zoonoses/rabies/docs/nys_rabies_treatment_guidelines.pdf

RABIES POST-EXPOSURE PROPHYLAXIS (Immune Globulin and Rabies Vaccine):
Must be preauthorized by the Health Department. If you plan to administer rabies post-exposure prophylaxis, please call 315-435-3236 (after hours 315-435-3165) for preauthorization.

Victim: _____ (Name) _____ (Date of Birth) **Sex:** ☐ **M** ☐ **F** **Complaint No.** _____

Address: _____ (Street) _____ (City) _____ (ZIP Code) **Phone:** _____

If victim is a MINOR, name of parent or legal guardian: _____

Owner of Animal: _____ (Name)

Address: _____ (Street) _____ (City) _____ (ZIP Code) **Phone:** _____

Owner Notified? ☐ **Yes** ☐ **No** **By Whom:** _____ (Name) **When Notified:** _____ (Date and Time)

Location of Occurrence: _____ (Address) _____ (ZIP Code)

Where is the animal now? _____ (Address) _____ (ZIP Code)

Where victim was treated: _____ **When:** _____ (Date and time of treatment) **By:** _____ (Name of doctor providing treatment)

Treatment Provided
(Antibiotics, X-Rays, stitches, etc.)**:** _____

CALL COMMUNICABLE DISEASE AT 315-435-3236 (AFTER HOURS 315-435-3165) FOR PREAUTHORIZATION OF RABIES POST EXPOSURE PROPHYLAXIS

Name of veterinarian: _____ **Vaccination status of animal:** _____

Remarks: ***(Describe location and severity of bite, and all other pertinent data not listed above)***

Reported by: _____ **Agency:** _____ **Phone:** _____