

ANIMAL BITE INTAKE REPORT

Infectious Disease Reporting System (IDRS)
Columbus Public Health

**Submit report within 24 hours.
Complete form and fax to 614-645-7155.**

Ohio Administrative Code 3701-3-28 states: "Whenever a person is bitten by a dog or other mammal, report of such bite shall be made within 24 hours to the health commissioner of the district in which such bite occurred. The report herein required shall be made by any health care provider, or by any licensed doctor of veterinary medicine with knowledge of the bite, or by the individual bitten."

This document and the information contained herein is a public record and may be released upon request pursuant to R.C. 149.43. Pursuant to the Health Insurance Portability and Accountability Act (HIPAA), one or more fields on this form may be redacted unless a disclosure exception in 45 CFR §164.512 applies.

TO BE COMPLETED BY THE HUMAN MEDICAL OR VETERINARY MEDICAL FACILITY

Facility Name: _____ Clinician: _____
Address: _____ City: _____ ZIP: _____
Phone #: _____ Human Rabies Post Exposure Treatment Started? ☐ No ☐ Yes

Please complete as much information as possible.

INCIDENT DETAILS

Date of Incident: ____/____/____
Incident Location Address: _____ City: _____ State: _____
Location of Incident (check one): ☐ On the animal owner's property ☐ Off the animal owner's property

VICTIM DETAILS

Victim's Name: _____
Victim's Address: _____ City: _____ State: _____ ZIP: _____
Phone #: (Home) _____ (Work) _____ (Cell) _____
Sex: ☐ Male ☐ Female Age: _____ Type Of Injury: ☐ Bite ☐ Scratch ☐ Bruise ☐ Other
Location of Injury(ies) on Body: _____
Parent/Guardian (if under 18): _____
Parent/Guardian Address (if different than victim): _____
Parent/Guardian Phone # (if different than victim): _____

ANIMAL DETAILS

Animal Type: ☐ Dog ☐ Cat ☐ Ferret ☐ Bat ☐ Raccoon ☐ Skunk ☐ Other: _____
Animal Color: _____ Breed: _____ Animal Name: _____
Where is the animal now? _____ Stray Animal? ☐ Yes ☐ No
Do you believe the animal is vaccinated for rabies? ☐ Yes ☐ No
Rabies Tag # (if known): _____ Veterinarian/Clinic: _____

OWNER DETAILS

Owner's Name (if known): _____
Owner's Address: _____ City: _____ State: _____ ZIP: _____
Phone #: (Home) _____ (Work) _____ (Cell) _____