

INCIDENT/BITE REPORT
LIVINGSTON COUNTY DEPARTMENT OF HEALTH
Center for Environmental Health
(585)243-7280 Fax: (585)243-6793

1. TOWNSHIP/VILLAGE where incident occurred: _____ COUNTY _____
 ADDRESS where incident occurred: _____
 DATE of incident: _____ TIME of incident: _____ AM/PM

2. If a **PERSON** was bitten, complete this section. If a **DOMESTIC ANIMAL** was bitten, complete section 3.

HUMAN BITE VICTIM	NAME		DOB	PARENT'S NAME (if child)		
	ADDRESS			PHONE		
	SITE OF BITE/SCRATCH		SKIN BROKEN? Yes No	BITTEN THROUGH CLOTHING? Yes No		
	WOUND TREATMENT		DATE OF TREATMENT	ANTI-RABIES PROPHYLAXIS GIVEN? Yes No		
	PRIMARY CARE PROVIDER		PCP PHONE	***PLEASE ADVISE PATIENT THAT THEY WILL BE CONTACTED BY THE DEPARTMENT OF HEALTH***		

3. If a **DOMESTIC ANIMAL** was bitten, complete this section.

DOMESTIC ANIMAL BITE VICTIM	ANIMAL NAME	TYPE OF ANIMAL	BREED	SEX	AGE	
	OWNER NAME			OWNER PHONE		
	DESCRIBE INJURIES			WOUND TREATMENT		
	RABIES VACCINATION? Yes No Unknown	WHERE GIVEN?		PRIMARY CARE VETERINARIAN		
	ANIMAL CURRENTLY ALIVE? Yes No	If vaccinated, will booster be given within 5 days? Yes No		If not vaccinated, will animal be quarantined for 6 months? Yes No		

4. Complete this section for **BITING ANIMAL**. Leave any unknown fields blank.

BITING ANIMAL	TYPE OF ANIMAL	ANIMAL NAME	COLOR	BREED	DOMESTIC ANIMAL Or WILD/FERAL ANIMAL	SEX	AGE	
	OWNER NAME				OWNER PHONE			
	RABIES VACCINATION? Yes No Unknown	WHERE GIVEN?			PRIMARY CARE VETERINARIAN			
	ANIMAL CURRENTLY ALIVE? Yes No	Will animal be euthanized for testing? Yes No		ANIMAL'S CURRENT LOCATION				
	If DOMESTIC ANIMAL is subject to 10 day confinement, confinement location:					***CONTACT THE LIVINGSTON COUNTY DEPARTMENT OF HEALTH TO SUBMIT ANIMAL FOR TESTING***		

5. Briefly describe the circumstances of the bite:

FORM COMPLETED BY: _____ DATE: _____ TIME: _____ AM/PM

FAX COMPLETED REPORT TO LIVINGSTON COUNTY DEPARTMENT OF HEALTH (585)243-6793
THIS IS A CONFIDENTIAL FAX LINE