# ANIMAL BITE INTAKE REPORT

## Communicable Disease Reporting System (CDRS)

Ohio Administrative Code 3701-3-38 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."

**TO BE COMPLETED BY THE TREATING FACILITY**

FACILITY: O'bleness Hospital PHYSICIAN: Dr. Dull

ADDRESS: 55 hospital Dr. CITY: Athens ZIP CODE: 45701

PHONE#: 740-592-9349 RABIES POST EXPOSURE TREATMENT STARTED? NO YES

Denied shot

*Please complete as much information as possible.*

**VICTIM (PERSON INJURED)**

DATE OF INJURY: 9/14/18

VICTIM'S NAME: James Eugene Wilson

STREET ADDRESS: 284 West St Rt 266

CITY: Stockport STATE: OH ZIP: 43787

PHONE#: (HOME) (WORK) (CELL) 614-3829562

SEX: (MALE) FEMALE AGE: 7 TYPE OF INJURY: (BITE) SCRATCH BRUISE OTHER

LOCATION OF INJURY(IES) ON BODY: Left hand in between Index and Middle finger

WAS THE VICTIM INJURED... (ON THE ANIMAL OWNER'S PROPERTY) OR OFF THE ANIMAL OWNER'S PROPERTY

PARENT/GUARDIAN (if under 18): Autumn Wilson

ADDRESS (if different than victim): PHONE#:

**ANIMAL**

ANIMAL TYPE: (DOG) CAT FERRET BAT RACCOON SKUNK OTHER

ANIMAL COLOR: Brindle BREED: Pitbull ANIMAL NAME: Dax

WHERE IS THE ANIMAL NOW? Locked in room STRAY ANIMAL? YES (NO)

DO YOU BELIEVE THE ANIMAL IS VACCINATED FOR RABIES? (YES) NO

RABIES TAG # (if known) VETERINARIAN/CLINIC:

**OWNER or LOCATION of ANIMAL**

If the animal owner is not known, please indicate in the address section where the injury occurred (i.e. street or nearest intersection)

OWNER'S NAME: Same as Victim

STREET ADDRESS:

CITY: STATE: ZIP:

PHONE#: (HOME) (WORK) (CELL)

**PLEASE FAX THIS REPORT WITHIN 24 HOURS TO THE APPROPRIATE HEALTH DEPARTMENT!**



For Questions Call OhioHealth O'Bleness Emergency Department 740.592.9349

hioHealth

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**TO BE COMPLETED BY THE TREATING FACILITY**

FACILITY: Coleman PHYSICIAN: Christopher Alto PA

ADDRESS: 55 O'Bleness Hospital Dr CITY: Athens ZIP CODE: 45701

PHONE#: 740 592 9349 RABIES POST EXPOSURE TREATMENT STARTED? (NO) YES

*Please complete as much information as possible.*

**VICTIM (PERSON INJURED)**

DATE OF INJURY: 9 / 14 / 18

VICTIM'S NAME: Mackenzie Wilson

STREET ADDRESS: 4700 beach rd Glouster

CITY: Glouster STATE: Oh ZIP: 45732

PHONE#: (HOME) (740) 877-8350 (WORK) _____ (CELL) (740) 541-8211

SEX: MALE (FEMALE) AGE: 19 TYPE OF INJURY: (BITE) SCRATCH BRUISE OTHER _____

LOCATION OF INJURY(IES) ON BODY: mouse/mouth

WAS THE VICTIM INJURED... (ON THE ANIMAL OWNER'S PROPERTY) OR OFF THE ANIMAL OWNER'S PROPERTY

PARENT/GUARDIAN (If under 18): _____

ADDRESS (if different than victim): _____ PHONE#: _____

**ANIMAL**

ANIMAL TYPE: (DOG) CAT FERRET BAT RACCOON SKUNK OTHER _____

ANIMAL COLOR: White BREED: Great Dane Mix ANIMAL NAME: Remington

WHERE IS THE ANIMAL NOW? patients residence STRAY ANIMAL? YES (NO)

DO YOU BELIEVE THE ANIMAL IS VACCINATED FOR RABIES? (YES) NO

RABIES TAG # (if known) _____ VETERINARIAN/CLINIC: Old Falls

**OWNER or LOCATION of ANIMAL**

If the animal owner is not known, please indicate in the address section where the injury occurred (i.e. street or nearest intersection)

OWNER'S NAME: David Hays

STREET ADDRESS: 4700 beach Rd

CITY: Glouster STATE: Oh ZIP: 45732

PHONE#: (HOME) _____ (WORK) _____ (CELL) (740) 680-3954

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CDRS Animal Bite Report Revised 09/14

OhioHealth

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