Animal Exposure Reporting Form

Please swipe Hospital Card or fill in Patient Information

HALIBURTON, KAWARTHA, PINE RIDGE DISTRICT HEALTH UNIT

To Report - Business hours: FAX to 905-885-1947
After hours: Phone: 1-888-255-7839 & FAX to 905-885-1947

Date Reported (dd/mm/yy)	Reported by	Telephone Number

Patient Information

Victim (Name)		Address	Home telephone
Parent/Guardian			
Health Card #			
Date of birth (dd/mm/yy)	Sex ☐M ☐F	City / Postal Code	Business telephone
Nature of Exposure ☐Bite ☐Scratch ☐Saliva ☐Other - describe			
Description and Location of Wound Contact (be specific)			
Attending Physician (name, address, phone no.)			
Family Doctor (name, address, phone no.)			
Nature of treatment ☐N/A ☐Cleansed ☐Sutures ☐Bandaged ☐Tetanus ☐Antibiotics			

I consent to the release of the above information to the municipal animal control agency for further investigation of this incident, for compliance with any animal control and licencing provisions, and to the local police service, for its determination of whether a criminal investigation is warranted.

Signature: Print Name: Date:

Incident

Date Incident Occurred (dd/mm/yy)	Time	Place/Address where incident occurred	
Circumstances of Incident ☐Provoked ☐Unprovoked	Other Human Involvement ☐Yes ☐No		
Description of Incident			

Animal Information

Type of Animal ☐dog ☐cat ☐other	Description (breed, colour, name)	Sex ☐M ☐F	Est. Age	☐Indoor ☐Outdoor ☐Both	
Owner (custodian)	Home phone	Cell phone	Is animal vaccinated against Rabies? ☐Yes ☐No ☐Unknown Vaccination Date		
Address	City	Postal Code			

For Health Care Practitioners Only

Name of Organization Reporting:

Health Care Facility where rabies biologicals are to be delivered to:

REQUIRED INFORMATION

Requesting Rabies Post Exposure Prophylaxis

❑ **No** ❑ **Yes (Public Health must be consulted)**

Immunity Status

☐ **Immunocompetent**

☐ **Immunocompromised**

Patient Weight

_____

☐kgs ☐lbs

Signature of Health Care Practitioner Date

O:Jan 00
R: Mar 18
R: Feb 20

Any personal and personal health information that you may provide on this form is collected under the authority of relevant legislation including: the Health Protection and Promotion Act, as amended, the Regulated Health Professions Act, the Immunization of School Pupils Act, and the Personal Health Information Protection Act. This information will be used for assessment, management, treatment and reporting purposes. Your information may be shared within the Health Unit and as required by legislation. For information about the collection, use and disclosure of your information, please refer to the Health Unit website at www.hkpr.on.ca or contact the Medical Officer of Health at 200 Rose Glen Road, Port Hope, Ontario, L1A 3V6 or 1-866-888-4577.