**Patient Information**

|  |  |
| --- | --- |
| Last Name: | First Name: |
| UNT ID: | Faculty Staff Student Other |
| Phone: | E-mail Address: |
| IACUC Protocol#: | Principal Investigator: |
| Last Tetanus Date:  | Last Rabies Vaccination/Titer Date (if applicable): |
| Primary Care Physician Name:  | Primary Care Physician Phone: |

**Incident Information**

|  |  |
| --- | --- |
| Date of Incident: | Approx. Time of Incident : |
| Location:  | Animal: Wild Domestic Research |
| Species/Description:  | Animal ID: | Type of Exposure: Bite Scratch Saliva to mucous membrane Other |
| Incident Description (include as much information as possible about the wound location, severity, number of wounds, etc.): |

**Medical Assessment**

|  |
| --- |
| Treatment or Medication (ie.: cleaned, bandaged, received immunization, etc.): |
| Were you seen by a Medical Provider? Yes No | If Yes, Name of Provider: | Address of Provider:  |

**To be completed by Veterinary Staff:**

|  |  |
| --- | --- |
| Does the animal require quarantine? Yes NoIf yes, Start Date: End Date: | Specimen sent for Rabies Testing? Yes No N/AIf yes, Date sent: (*Please attach copy of results*) |
| Considerations/Comments/Notes: |

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 Veterinarian or Supervisor Name Signature Date