**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 No  If yes, Start Date: End Date: | Specimen sent for Rabies Testing? Yes No N/A  If yes, Date sent: (*Please attach copy of results*) |
| Considerations/Comments/Notes: | |

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Veterinarian or Supervisor Name Signature Date