Lakelands Public Health

Please swipe Hospital Card or fill in Patient Information

Animal Exposure Reporting Form

To Report - During business hours (Mon-Fri 8:30a.m.-4:30p.m.) Phone: 1-844-575-4567
CMH, HHHS, NHH, RMH - Fax: 905-885-1947 PRHC - Fax: 705-743-1203
After hours (must phone AND fax):
CMH, HHHS, NHH, RMH - Phone: 1-888-255-7839 Fax: 905-885-1947
PRHC - Phone: 705-760-8127 Fax: 705-743-1203

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

Patient Information

Victim (Name)		Home telephone	
Parent/Guardian		Address	
Health Card #			
Date of birth (dd/mm/yy)	Sex ☐ M ☐ F	City	Postal Code / Client telephone number

Nature of Exposure ☐ Bite ☐ Scratch ☐ Saliva ☐ Bat ☐ Other – describe

Description and Location of Wound Contact (be specific)

Attending Physician (name, address, phone no.)

Family Doctor (name, address, phone no.)

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	
Circumstances of Incident ☐ Provoked ☐ Unprovoked	Other Human Involvement ☐ Yes ☐ No	

Description of Incident

Animal information

Type of Animal ☐ Dog ☐ Cat ☐ Bat ☐ Stray ☐ Wild ☐ Other	Description (breed, colour, name)	Sex ☐ M ☐ F	Est. Age	☐ Indoor ☐ Outdoor ☐ Both

Imported to Canada in the last 6 months ☐ Yes ☐ No If Yes, Country of origin:

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	Patient Weight
☐ **Immunocompetent** ☐ **Immunocompromised**	_____ ☐ kgs ☐ lbs

Signature of Health Care Practitioner Date

O: Jan 00
R: Feb 20
R: Nov 25

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 **LakelandsPH.ca** or contact the Medical Officer of Health at 185 King Street, Peterborough ON, K9J 2R8 or **1-844-575-4567**.