



ANIMAL CONTACT INCIDENT REPORT

Hedgehog Investigation #: _____ (For Office Use Only)

Date Reported:	YEAR	MONTH	DAY	Reported by: _____
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PATIENT / VICTIM INFORMATION

Name:			Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/>	
Parent Guardian Name (if patient is under 16 yrs of age):				
Date of Birth:	YEAR	MONTH	DAY	Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
Address: (permanent)				
Address: (temporary)				

INCIDENT DETAILS

Date of incident:	YEAR	MONTH	DAY	Family/Attending Physician:
Location of incident:				
Body area affected:				
Skin broken:		<input type="checkbox"/> Bite <input type="checkbox"/> Scratch <input type="checkbox"/> Saliva <input type="checkbox"/> Handling <input type="checkbox"/> Other _____		
Details of Incident:				

ANIMAL INFORMATION (or person with custody of animal)

Owner:	Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
Address: (permanent)	
Address: (temporary)	
Animal Species: <input type="checkbox"/> Dog <input type="checkbox"/> Cat <input type="checkbox"/> Bat <input type="checkbox"/> Other _____ <input type="checkbox"/> Domestic <input type="checkbox"/> Farm <input type="checkbox"/> Stray <input type="checkbox"/> Wild <input type="checkbox"/> Rescue	
Breed and full description:	
Vaccination status: <input type="checkbox"/> Vaccinated <input type="checkbox"/> Unvaccinated <input type="checkbox"/> Unknown vaccination	
Where is animal located now:	

Telephone and fax form to Northeastern Public Health within 24 hours
 Telephone: 1-877-442-1212 (press '1' if calling outside of business hours)
 Confidential fax number: 705-360-7324

All persons having information concerning any animal contact incidents are required to notify the Medical Officer of Health under the Health Protection and Promotion Act, Reg.557. Personal information on this form is collected under the Health Protection and Promotion Act in accordance with the Municipal Freedom of Information and Protection of Privacy Act for the purposes of providing health services.

RABIES POST-EXPOSURE PROPHYLAXIS (rPEP) ASSESSMENT BY HEALTH CARE PROVIDERS

For information about assessing the need for rPEP, please visit:

- *Reporting by Health Professionals* webpage by Northeastern Public Health, available at: <https://www.neph.ca/en/for-professionals/health-professionals>.
- *Management of Potential Rabies Exposures Guideline, 2020* by the Ministry of Health, available at: <https://files.ontario.ca/moh-guidelines-management-of-potential-rabies-exposures-guideline-en-2020.pdf>
- *Management of Patients with Suspected Rabies Exposure, 2017* by Public Health Ontario, available at: <https://www.publichealthontario.ca/-/media/documents/R/2017/rabies-exposure-guidance-hcps.pdf>

Northeastern Public Health will complete the risk assessment with the health care provider to determine whether the individual requires rPEP. Contact a Public Health Inspector by calling 1-877-442-1212 (press '1' if calling outside of business hours).

<p>To be completed by health care provider only if Post-Exposure Prophylaxis is initiated at the hospital and only after consultation with a Public Health Inspector by calling 1-877-442-1212 (press '1' if calling outside of business hours).</p>	
<p>Please Complete the Following and Fax Page 2:</p>	
<p>Date & Provider: _____</p>	
<p>Patient weight: _____ <input type="checkbox"/>kg _____ <input type="checkbox"/>lbs</p>	<p>Tetanus Date: _____ Vaccine Name: _____ Lot Number: _____</p>
<p>Is Patient considered immunocompromised: _____ <input type="checkbox"/>No _____ <input type="checkbox"/> Yes</p>	<p>Has Patient previously completed a full course of rabies immunization: _____ No _____ Yes</p>
<p>Agent: Rabies Immune Globulin (Dose of 20 IU/kg should not be exceeded)</p> <p>Type: <input type="checkbox"/>Imogam <input type="checkbox"/>HyperRAB <input type="checkbox"/>KamRAB # Vials: _____ Lot Number(s): _____ Expiry Date(s): _____ Site of injection: _____</p>	<p>Agent: Rabies Vaccine inactivated</p> <p>Vaccine Name: <input type="checkbox"/>IMOVAX Rabies <input type="checkbox"/>RABAVert Dose: _____ Lot Number(s): _____ Expiry Date(s): _____ Site of injection: _____</p>