

ARKANSAS DEPARTMENT OF HEALTH

Public Health Laboratory

Rabies Examination Form

<p>Submitter's Information</p> <p>Agency _____</p> <p>Name _____</p> <p>Address _____</p> <p>City _____ State _____ Zip _____</p> <p>County _____ Phone _____</p>	<p>Owner's Information</p> <p>Name _____</p> <p>Address _____</p> <p>City _____ State _____ Zip _____</p> <p>County _____ Phone _____</p>
<p>Person Bitten by this Animal</p> <p>Name _____</p> <p>Address _____</p> <p>City _____ State _____ Zip _____</p> <p>County _____ Phone _____</p>	<p>Animal Bitten by this Submitted Animal</p> <p>Kind of Animal _____ Owner _____</p> <p>Address _____</p> <p>City _____ State _____ Zip _____</p> <p>County _____ Phone _____</p>
<p>INFORMATION ON SUBMITTED ANIMAL</p>	
<p>Specify Kind of Animal</p> <p><input type="checkbox"/> Dog <input type="checkbox"/> Skunk (Circle)</p> <p><input type="checkbox"/> Cat Striped Spotted Not Sure</p> <p><input type="checkbox"/> Cow <input type="checkbox"/> Fox (Circle)</p> <p><input type="checkbox"/> Bat Red Gray Not Sure</p> <p><input type="checkbox"/> Other (Specify) _____</p>	<p>Location Submitted Animal Found <input type="checkbox"/> At Owner's Home</p> <p>Address _____ County _____</p> <p>City _____ State _____ Zip _____</p> <p>Date Animal Died ____/____/____</p> <p><input type="checkbox"/> Natural Death <input type="checkbox"/> Killed <input type="checkbox"/> Unknown</p>
<p>Was Submitted Animal Bitten by Another Animal?</p> <p><input type="checkbox"/> Yes, When? ____/____/____ <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	<p>Was Submitted Animal Vaccinated Against Rabies?</p> <p><input type="checkbox"/> Yes, When? ____/____/____ <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>
<p>Information about the veterinarian who observed the animal</p> <p>Address _____</p>	<p>Name _____ Phone _____</p> <p>City _____ State _____ Zip _____</p>
<p>Noted Symptoms:</p> <p><input type="checkbox"/> Slobbering <input type="checkbox"/> Paralysis <input type="checkbox"/> Other (Specify) _____</p> <p><input type="checkbox"/> Difficulty in Swallowing <input type="checkbox"/> Unusual Viciousness _____</p> <p><input type="checkbox"/> Restlessness & Excitability <input type="checkbox"/> Change in Voice _____</p> <p><input type="checkbox"/> Sagging Jaw <input type="checkbox"/> Unable to Close Mouth _____</p>	
<p>LABORATORY USE ONLY</p> <p>(Do not write in this section)</p> <p><input type="checkbox"/> Negative <input type="checkbox"/> Positive</p>	
<p>Microscopic Exam of Brain Material for Rabies was:</p> <p><input type="checkbox"/> Unsatisfactory _____</p>	
<p>Specimen Number _____ Date / Time Received ____/____/____ :____ Test Completed on ____/____/____</p> <p>Ship via _____ Analyst _____ Results Reported to _____ on ____/____/____</p>	