



GEORGIA DEPARTMENT OF PUBLIC HEALTH
PUBLIC HEALTH LABORATORY

RABIES SUBMISSION FORM

SUBMITTER INFORMATION	PATIENT INFORMATION
SUBMITTER CODE: <div style="display: flex; justify-content: space-around; width: 100%;"> <div style="border: 1px solid black; width: 25px; height: 25px;"></div> <div style="border: 1px solid black; width: 25px; height: 25px;"></div> <div style="border: 1px solid black; width: 25px; height: 25px;"></div> <div style="border: 1px solid black; width: 25px; height: 25px;"></div> <div style="border: 1px solid black; width: 25px; height: 25px;"></div> <div style="border: 1px solid black; width: 25px; height: 25px;"></div> </div> CLINIC NAME: _____ _____ STREET: _____ _____ CITY: _____ STATE _____ ZIP CODE: _____ PHONE NO: _____ FAX NO: _____ CONTACT NAME: _____	CASE/BITE number: _____ Name and Address of Person Exposed/Owner of Animal/Submitter (circle one) NAME: _____ <div style="display: flex; justify-content: space-around; width: 100%;"> Last First Middle </div> RESIDENCE: _____ <div style="display: flex; justify-content: space-around; width: 100%;"> Street City State Zip </div> _____ / _____ / _____ County _____ DOB _____ Other Persons Exposed: NAME _____ DOB _____ / _____ / _____ NAME _____ DOB _____ / _____ / _____ NAME _____ DOB _____ / _____ / _____

SPECIMEN INFORMATION		
Date of Collection: _____ / _____ / _____ Species of Animal Submitted: <input type="checkbox"/> Bat <input type="checkbox"/> Cat <input type="checkbox"/> Dog "Breed" _____ <input type="checkbox"/> Fox <input type="checkbox"/> Raccoon <input type="checkbox"/> Skunk <input type="checkbox"/> Other _____ Animal Classification: <input type="checkbox"/> Pet <input type="checkbox"/> Wild <input type="checkbox"/> Stray	Date Killed: _____ / _____ / _____ Reason for Testing: (mandatory, check all that apply) <input type="checkbox"/> Human exposure <input type="checkbox"/> Domestic animal exposure <input type="checkbox"/> Epidemiological Reasons <input type="checkbox"/> Other _____ Exposure Type: <input type="checkbox"/> Bite <input type="checkbox"/> Contact Saliva <input type="checkbox"/> Scratch <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____	County of Animal _____ Clinical Information: Domesticated animal vaccination status: <input type="checkbox"/> Current <input type="checkbox"/> None <input type="checkbox"/> Expired <input type="checkbox"/> Unknown Veterinarian who observed animal/phone number _____ Has animal recently fought with a suspected rabid animal? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, date: _____