Reporting Forms

VETERINARY PUBLIC HEALTH-RABIES CONTROL PROGRAM

TEL: (213)-989-7060 or (877) 747-2243 FAX: (213) 481-2375
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BITE REPORTING FORM - VETERINARY CLINICS

PERSON BITTEN

Victim name (last and first)	Date of Birth	Address (number, street, city and zip)

Victim phone number	Reported by:	Reporter phone number

Date bitten	Time bitten	Address where bitten (if no address make sure to put city and zip code)	Body location bitten

How bite occurred (explain)

Date Treated	Hospitalized	Treated by	Phone number
	☐ Yes ☐ No		

Type of treatment

ANIMAL

Owner Name (last and first)	Address (number, street city and zip)

Phone Number	Type of animal	Description of animal (sex, color)
	☐ Dog Breed _____ ☐ Cat Breed _____ ☐ Other _____	

Animal vaccinated for rabies?	Date last vaccinated:	Animal sterilized?
☐ Yes ☐ No		☐ Yes ☐ No

Was animal euthanized?	Reason euthanized:	Specimen prepared for rabies testing?
☐ YES ☐ NO Date _____	☐ Injured ☐ Sick ☐ other Please explain:	☐ Yes ☐ No ☐ Not applicable

CLINIC

Clinic Information Name:	Contact person

Address (include number, street, city, state and zip)	Phone Number

Remarks

Clinic Taking Report:

Date	Time	Faxed: ☐ yes ☐ No	Initials

VETERINARY PUBLIC HEALTH – RABIES CONTROL PROGRAM

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County of Los Angeles Public Health

DOMESTIC ANIMAL VS. WILD MAMMAL INCIDENT REPORT FORM

DOMESTIC ANIMAL – PET INFORMATION				
Owner last name	Owner first name	Owner address. Number and street		City and zip code
Owner area code & phone	Species ☐ Dog ☐ Cat	Breed	Sex	Age
Date bitten / Time bitten	Reported by		Reporter area code & phone number	
Address where bitten. Number and street	City and zip code		Type of injury to domestic animal	
Animal vaccinated prior to contact with wildlife? ☐ Yes ☐ No	Date vaccinated prior to contact with wildlife:	Animal vaccinated after coming into contact with wildlife? ☐ Yes ☐ No	Date vaccinated after coming into contact with wildlife:	
Domestic animal impounded? ☐ Yes ☐ No	Animal Shelter	Impound #	Was animal euthanized? ☐ Yes ☐ No	
Was animal taken to vet? ☐ Yes ☐ No	Name of Veterinarian Hospital	Address, city and zip		
Current location of animal: ☐ Home address	☐ Veterinary clinic listed above	☐ Other _____		

WILD LIFE INFORMATION (animals other than dog or cat)			
Type of wild animal ☐ Coyote ☐ Skunk ☐ Raccoon ☐ Bat ☐ Other (explain)	Wild animal disposition: ☐ Left area/not located ☐ Appeared sick ☐ Captured/destroyed/died		
Wild animal specimen prepared for rabies testing? ☐ Yes ☐ No ☐ Not applicable	Location of wild animal specimen (clinic or shelter)	Date euthanized	Time
Veterinary Clinic or Animal Control Agency taking report:	Impound# of wild animal (if applicable)		
Comments:			
Report by:	Date taken:	Initials Faxed by:	Date:

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BAT SUBMISSION FORM

INSTRUCTION:

- **All bats submitted to animal shelters must be reported to the Health Department immediately.**
- **Please *FAX* all information to (213) 481-2375**
- **Fill out as much information as possible.**
- **DO NOT DECAPITATE specimen.**
- **DO NOT FREEZE specimen.**

1. Bat Impound # _____ **Date** _____

Shelter _____ **ACO** _____

Phone Number _____

2. Name of person who captured bat _____

3. Name of owner/business where bat was found _____

4. Address (where found) _____

Phone Number of premise _____

5. Capture location of bat ☐ **Home** ☐ **Garage** ☐ **Business** ☐ **Outdoors**
☐ **Other** _____

Time of capture or pickup _____

6. Method used to capture bat _____

---

1. State of bat when captured (check one) ☐ **Live or** ☐ **Dead**

2. Did any people or animals have any physical contact with bat? ☐ **Yes** ☐ **No**

If so, explain: _____

Names:	**Addresses:**	**Phone:**

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Animal Disease/Death Reporting Form

(if the disease you are reporting has a specific form, ideally use that form instead)

Date form completed_____

SUSPECTED DISEASE/CONDITION BEING REPORTED: _____

1. Animal Information

Type of animal involved: □ Domestic Pet □ Livestock □ Wild animal
□ Exotic □ Zoo animal
Number of animals: □ One □ Multiple (give number _____)
Species of Animal _____
Other Identifying Information:
Breed _____ Color _____
Sex _____ Name _____
Age _____ IMPOUND # _____

2. Animal Owner (if applicable)

Name(s)
Address
City, ZIP
Telephone:
Is it okay for Public Health to call the owner(s) to ask more about the history? □ YES □ NO

2. Animal Location (where in community originally found, if not same as owner)

Name(s)
Address
City, ZIP

3. Reporting Veterinarian

Name of veterinarian or technician:
Vet Clinic Name:
Address:
City, ZIP:
Telephone Fax E-mail:

4. History

Date of onset of first symptoms_____ Date of presentation_____
Date of death(s), if applicable_____
History (include vaccine history, if applicable):

Fax 2-page form to: (213) 481-2375 **2010**
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5. Clinical Findings

Highest body temperature measured_____

Physical Examination

	Normal		Comments
General:	□ Yes	□ No	_____
Skin:	□ Yes	□ No	_____
Head Area:	□ Yes	□ No	_____
Respiratory:	□ Yes	□ No	_____
Cardiovascular:	□ Yes	□ No	_____
Abdomen/digestive:	□ Yes	□ No	_____
Urogenital:	□ Yes	□ No	_____
Musculoskeletal:	□ Yes	□ No	_____
Nervous:	□ Yes	□ No	_____
Lymph nodes:	□ Yes	□ No	_____
Other:	□ Yes	□ No	_____

6. Treatment.

Please describe treatment given, particularly antibacterial, antiviral, antifungal, antiparasitic.

Treatment Date	Describe Treatment
1. _____	_____
2. _____	_____
3. _____	_____

7. Laboratory results

Please fax all laboratory results to us along with this form.

8. Additional comments.

Please use an additional sheet if needed.

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Public Health

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Canine Brucellosis Reporting Form

Date form completed_____

1. Dog

Name_____Breed_____Sex/Neut_____Age_____

2. Dog Owner

Name(s)
Street :
City, ZIP
Telephone:
Is it okay for Public Health to call the owner(s) to ask more about the history? YES NO

3. Reporting Veterinarian

Name of veterinarian or technician:
Vet Clinic Name:
Address:
City, ZIP:
Telephone Fax E-mail:

4. Exposure History

•How long has the owner had the dog?_____
•Where did the owner get the dog? Please list name and address of animal shelter/rescue group/breeder/private party._____
_____
• If this dog is spayed/neutered, please note the approximate date of the procedure_____
• Are there any other dogs in the household?.....□ YES □ NO
If YES, how many other dogs are in the home?_____
• Do any other dogs in the household have the same clinical signs? ……. ……..□ YES □ NO
•Has the dog ever mated with another dog (intentional breeding or not)?.....□ YES □ NO
(If YES, please fill out another form for the dog with which it mated.)
• Has this dog ever been in contact with cattle, goats, sheep, pigs, deer, or rodents?.....□YES □ NO
If YES, please describe_____
• Is there any known illness in humans that handled the dog? ……. ……...□ YES □ NO

5. Clinical Findings

Date of onset of first symptoms_____Date of presentation_____
Date of death (if applicable)_____
Highest body temperature measured _____
Check all that apply:
□ no clinical signs □ fever □ lethargy □ exercise intolerance
□ urinary tract infection □ abortion □ diskospondylitis □ epididymitis
□ ocular lesions □ enlarged lymph nodes. Node locations:_____
□ other_____

6. Laboratory results.

Please fax all laboratory results to us along with this form.

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Coccidioidomycosis Reporting Form

Date form completed_____

1. Pet
□ Dog □ Cat □ Other
Name_____Breed_____Sex/Neut_____Age_____

2. Pet Owner
Name(s) :
Street :
City, ZIP
Telephone:
Is it okay for Public Health to call the owner(s) to ask more about the history? □ YES □ NO

3. Reporting Veterinarian
Name of veterinarian or technician:
Vet Clinic Name:
Address:
City, ZIP:
Telephone Fax E-mail:

4. Exposure History
(fill in as known)

Dog lives primarily outdoors (more than 50% of time).	□ Yes	□ No
Dog likes to dig in soil frequently.	□ Yes	□ No
Dog/family live within site of earth excavation.	□ Yes	□ No
Dog/family live on a dirt road	□ Yes	□ No
Dog has been in dust storm within 2 months before illness.	□ Yes	□ No

Dog has been to the following locations within 2 months before illness:

□ Mojave Desert Area	□ Central Valley/San Joaquin Valley	□ Arizona
□ New Mexico	□ Southern Nevada	□ Southwestern Texas
□ Southern Utah	□ Northern Mexico	□ Central or South America

5. Clinical Findings
Date of onset of first symptoms_____Date of presentation_____
Date of death (if applicable)_____
Highest body temperature measured _____
Check all that apply:

□ Cough	□ Fever
□ Weight loss	□ Lameness
□ Enlarged lymph node(s) (node location(s)_____)	
□ Eye lesions	□ Pneumonia/Pulmonary lesion seen on radiograph
□ Bone lesion seen on radiograph	□ Other:_____

6. Laboratory results.
Please fax all laboratory results to us along with this form.

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Heartworm Reporting Form

Date form completed_____

1. Pet
□ Dog □ Cat
Name_____Breed_____Sex/Neut_____Age_____

2. Pet Owner
Name(s) :
Street :
City, ZIP
Telephone:
Is it okay for Public Health to call the owner(s) to ask more about the history? YES NO

3. Reporting Veterinarian
Name of veterinarian or technician:
Vet Clinic Name:
Address:
City, ZIP:
Telephone Fax E-mail:

4. Exposure History
Exposure/travel outside of LA County □ Yes □ No
If yes, please note location and date: _____
Other exposure _____

5. Clinical Findings
Date of onset of first symptoms_____Date of presentation_____
Date of death (if applicable)_____
Clinical Signs (check all that apply)
□ None □ Cough □ Fatigue □ Heart failure
□ Other _____
Thoracic radiographs taken? □ Yes □ No
If yes, please note date and comment on findings _____

6. Heartworm Tests and Treatment

Heartworm blood test date	Test type (Ag, Ab, microfilaria)	Test Result
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Treatment Date	Describe Treatment
1. _____	_____
2. _____	_____
3. _____	_____

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Canine Hemorrhagic Gastroenteritis (HGE) Reporting Form

Overview: In the winters of 2004, 2005, 2006, and 2008 seasonal outbreaks of mild to moderately severe bloody diarrhea in dogs in LA County were reported to this office. As of yet, no clear cause of the seasonality of this condition has been uncovered. Please continue to report cases.

Date form completed_____

1. Dog Information

Name _____Breed_____Sex _____
Age _____Color _____

2. Dog Owner

Name(s)
Address
City, ZIP
Telephone:
Is it okay for Public Health to call the owner(s) to ask more about the history? □ YES □ NO

3. Reporting Veterinarian

Name of veterinarian or technician:
Vet Clinic Name:
Address:
City, ZIP:
Telephone Fax E-mail:

4. Clinical Course

a. Date of onset of first symptoms_____ **b**. Date of presentation_____
c. Date of death(s), if applicable_____
d. Fever? YES NO If yes, highest temperature detected =_____
e. Clinical Signs (check all that apply):

□ Anorexia	□ Diarrhea-watery	□ Diarrhea - mucoid
□ Lethargy	□ Diarrhea – soft stool	□ Other clinical signs (list):
□ Vomiting	□ Diarrhea – bloody	
	□ Diarrhea - tarry/black stool	

f. Already recovered as of date form filled out? □ YES □ NO □ UNKNOWN
g. Rate of recovery if known (circle one):
□ Fast (1-2 days)
□ Slow (3-5 days)
□ Very Slow (6+ days)
□ Waxing and Waning – no clear recovery
□ No recovery – chronic illness or euthanized/died

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5. Exposure/Possible Causes

a. Did dog have any exposure to raw fish (especially Salmon or trout)? □ YES □ NO
b. Did the ill dog tend to eat dropped fruit or berries from trees in the environment? □ YES □ NO
c. Current brands of dry and canned dog food being fed:_____
_____
d. Current type, brands of treats (dry biscuits, jerky treats, rawhide, etc)_____
_____
e. Dietary indiscretion by dog in week before onset (i.e trash, swallowed a toy, etc)? □ YES □ NO
f. Dog's regular diet changed in the week before onset? □ YES □ NO
g. Any humans in the house have (or recently had) similar symptoms? □ YES □ NO
h. Any other dogs, cats, or other pets in the home have similar symptoms? □ YES □ NO
i. Any traveling with dog in the week before illness onset? □ YES □ NO
j. Does dog leave its property regularly (walks, escapes)? □ YES □ NO
k. Does dog have regular access to wildlife or feces/urine from wildlife? □ YES □ NO
l. Does owner/veterinarian have any theories about the cause of the dog's illness? □ YES □ NO

m. EXPLAIN. If there was a YES answer to any of the above questions, please use the space below to explain:

6. Treatment.

a. IV fluids administered? □ YES □ NO
b. Subcutaneous fluids administered? □ YES □ NO
c. Medications. Please **LIST** the names of all drugs (antibiotics,antiparasiotics, antidiarrheals, etc.) used and route of administration (IV, PO, SQ etc). You do not need to note the dose or frequency of use.

7. Laboratory results

a. In-house Parvo SNAP test result: □ Negative □ Positive □ Not done
b. In-house fecal testing (type of test, result)_____

c. Please FAX all laboratory results to us along with this form.

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Imported Animal Illness or Death Reporting Form

Animals that were recently imported from another country may be ill from diseases that are not common in Los Angeles County. Your reports help us to detect and limit the spread of imported diseases. Many imported animals are not inspected on entry.

Date form completed_____

1. Animal

Name_____Species_____Breed_____Sex/Neut_____Age_____

2. Animal Owner

Name(s):
Address:
City, ZIP:
Telephone:
Is it okay for Public Health to call the owner to ask more about the history? □ Yes □ No

3. Reporting Veterinarian

Name of veterinarian or technician
Vet Clinic Name:
Address:
City, ZIP
Tel Fax E-mail

4. Importation History

Country of origin, if known: _____
Date of importation, if known: _____
Was owner also importer of animal? □ Yes □ No
If No, animal purchased from
□ Newspaper classified □ Online classified ad
□ Pennysaver ad □ Retail pet store
□ Swap meet □ Other _____

5. Clinical Findings

Date of onset of first symptoms_____ Date of presentation_____
Date of death (if applicable)_____
Highest body temperature measured _____
Suspected illness or condition being reported (please describe):

6. Laboratory results.

Please fax all relevant laboratory results to us along with this form.

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Canine Influenza Reporting Form

Date form completed_____

1. Dog
Name_____Breed_____Sex/Neut_____Age_____

2. Dog Owner
Name(s) :
Street :
City, ZIP
Telephone:
Is it okay for Public Health to call the owner(s) to ask more about the history? □ YES □ NO

3. Reporting Veterinarian
Name of veterinarian or technician:
Vet Clinic Name:
Address:
City, ZIP:
Telephone Fax E-mail:

4. History
DHLPP. Date of last 2 – 3 DHPP or DHLPP vaccines if known _____ _____ _____
Bordetella. Date of last 2 Bordetella vaccines. _____ □ Intranasal □ Injectable
_____ □ Intranasal □ Injectable

Potential exposure history

□ Another sick dog in home □ Dog show □ Kennel visit
□ Exposure to stray □ Pet store □ Shelter visit
□ Dog park □ Other _____

5. Clinical Findings
Date of onset of first symptoms_____Date of presentation_____
Date of death (if applicable)_____
Highest body temperature measured: _____
Check all that apply:

□ Cough □ Nasal discharge □ Sneezing
□ Fever □ Chest X-rays taken □ Patient hospitalized
□ IV fluids given □ Supplemental oxygen given

If nasal discharge present, please note: color, consistency, uni- or bilateral: _____
If chest radiographs were taken, please describe what was seen: _____
Name of medications used in treatment: _____
Amount of time it took dog to recover: _____
Date(s) serum drawn _____
Other comments _____

6. Laboratory results - Please fax all laboratory results to us along with this form.

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Leptospirosis Reporting Form

Date form completed_____

1. Dog
Name_____Breed_____Sex/Neut_____Age_____

2. Dog Owner
Name(s)
Address
City, ZIP
Telephone:
Is it okay for Public Health to call the owner(s) to ask more about the history? □ YES □ NO

3. Reporting Veterinarian
Name of veterinarian or technician:
Vet Clinic Name:
Address:
City, ZIP:
Telephone Fax E-mail:

4. History
Vaccination
Date of last leptospirosis vaccine (if known): _____
Vaccine type (ex. DHLPP or 4-way Lepto vaccine): _____
Potential exposure history
Exposure/travel outside of Los Angeles County? □ Yes □ No
If yes, please note location and date: _____
Dog has/had local exposure to (check all that apply):
□ Skunks □ Opossums □ Raccoons □ Deer □ Rats
□ Mice □ Pigs □ Cattle □ Horses
Other potential exposure: _____

5. Clinical Findings
Date of onset of first symptoms_____Date of presentation_____
Date of death (if applicable)_____
Highest body temperature measured _____
Check all that apply:
□ Anorexia □ Lethargy □ Vomiting □ Diarrhea
□ Visible jaundice/icterus □ Polyuria □ Polydipsia
□ Other (describe):

Were intravenous fluids given? □ Yes □ No

6. Laboratory results
Please fax all laboratory results to us along with this form.

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Animal Methicillin-Resistant *Staphylococcus* Reporting Form

Please report all Methicillin-resistant *Staphylococcus* species, including *S. aureus* (MRSA), *S. schleiferi* (MRSS), and *S. pseudointermedius* (MRSP).

Date form completed_____

1. Animal □ Dog □ Cat □ Horse □ Bird □ Other _____
Name_____Breed_____Sex/Neut_____Age_____

2. Animal Owner
Name(s)
Address
City, ZIP
Telephone:
Is it okay for Public Health to call the owner(s) to ask more about the history? YES NO

3. Reporting Veterinarian
Name of veterinarian or technician:
Vet Clinic Name:
Address:
City, ZIP:
Telephone Fax E-mail:

4. Exposure History
Any associated human illness? □ YES □ NO
Any other animals in family ill from bacteria? □ YES □ NO

5. Clinical Findings
Date of onset at home_____Date of presentation_____Date of death (if applicable)_____
Check all that apply:
□ Fever (highest body temperature measured _____)
□ Abscess □ Skin lesions/dermatitis □ Skin lesion/mass-like
□ Otitis externa □ Urinary tract infection □ Post-operative infection
□ Intravenous catheter □ Surgical implant □ Septic arthritis
□ Other_____Location of lesion(s) on body_____
Were any pictures taken of the lesion(s)? □ Yes □ No

6. Treatment. Please comment on antibiotics administered and response to treatment.

7. Laboratory results. Please fax all bacterial cultures and other lab results in along with form.

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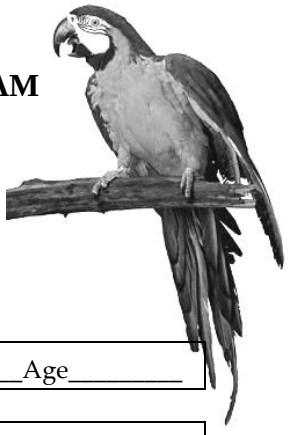

Avian Psittacosis Reporting Form

Date form completed_____

1. Bird. Name_____Species_____Sex(if known) _____Age_____

2. Bird Owner

Name(s)
Address
City, ZIP
Telephone:
Los Angeles County Public Health will contact the owner about the standard 45-day quarantine period.

3. Reporting Veterinarian

Name of veterinarian or technician:
Vet Clinic Name:
Address:
City, ZIP:
Telephone Fax E-mail:

4. History

a. How long has this person owned this bird?_____ Date bird obtained (if known)_____
c. Store/Individual selling bird to owner (if within last 60 days)_____
_____
d. Are there other birds on owner's property? □ No □ Yes
If yes, how many?_____
Is there any known illness in these other birds? □ No □ Yes
e. Were any new birds brought onto property recently? □ No □ Yes
If yes, explain_____
f. Type of housing of infected bird: □ Indoor □ Outdoor
g. Is there any known human respiratory illness in people that handle the infected bird? ? □ No □ Yes
If Yes, please explain_____

5. Clinical Findings

a. Date of onset of first symptoms_____
b. Date of presentation_____
c. Date of death (if applicable)_____
d. Check all that apply
□ No clinical signs □ Lethargy □ Anorexia □ Diarrhea □ Respiratory signs
□ Sudden death □ Other_____
□ Other (explain):

6. Diagnostics/Laboratory results.

Please fax all laboratory results to us along with this form.

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Canine Rocky Mountain Spotted Fever Reporting Form

Date form completed_____

1. Dog Name_____Breed_____Sex/Neut_____Age_____

2. Dog Owner
Name(s)
Address
City, ZIP
Telephone: May we call the owner(s) to ask more about the history? □ **YES** □ **NO**

3. Reporting Veterinarian
Name of veterinarian or technician:
Vet Clinic Name:
Address:
City, ZIP:
Telephone Fax E-mail:

4. Tick Exposure History
Type of neighborhood dog lives in: □ Urban □ Suburban □ Rural
Ticks found on dog within 7 days before illness: □ Yes □ No
Ticks found on dog within past 3 months: □ Yes □ No
Is the dog walked outside of its own neighborhood: □ Yes □ No
Locations of trails/parks/other places in LA County the dog visits:
_____
Does the dog visit places outside of LA County? □ Yes □ No
List locations outside of LA County the dog might have been exposed to ticks:

5. Clinical Findings
Date of onset of first symptoms_____Date of presentation_____
Date of death (if applicable)_____Highest body temperature measured _____
Check all that apply:
□ Fever □ Anorexia □ Petecchiae/ecchymoses □ Vomiting □ Diarrhea
□ Cough □ Enlarged peripheral lymph nodes □ Conjunctivitis/scleral injection
□ Seizures/vestibular disease/neuro □ Edema (body location _____)
□ Polyarthritis (joints involved _____)

6. Treatments: (Ex. antibiotics or corticosteroids, ectoparasite control)

7. Laboratory results. Please fax all laboratory results along with this form.

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Vaccine Preventable Disease Reporting Form

Date form completed_____

SUSPECTED DISEASE BEING REPORTED:

□ Parvovirus □ Canine distemper □ Panleukopenia □ Other_____

1. Pet

□ Dog □ Cat

Name_____Breed_____Sex/Neut_____Age_____

2. Pet Owner

Name(s)
Address
City, ZIP
Telephone:
Is it okay for Public Health to call the owner(s) to ask more about the history? YES NO

3. Reporting Veterinarian

Name of veterinarian or technician:
Vet Clinic Name:
Address:
City, ZIP:
Telephone Fax E-mail:

4. History

Relevant vaccine history, include dates of vaccine:

Is this case part of a cluster or outbreak? If yes, please explain:
Potential exposure history

□ Another sick animal in home □ Dog show □ Kennel visit
□ Exposure to stray □ Pet store □ Shelter visit
□ Dog park □ Other _____

5. Clinical Findings

Date of onset of first symptoms_____Date of presentation_____
Date of death (if applicable)_____Highest body temperature measured: _____
Check all that apply
□ Cough □ Nasal Discharge □ Vomit □ Diarrhea
□ Tremors □ Seizures □ Other neurological signs
□ Parvo snap test in-house - positive
□ Positive distemper titer with no prior vaccination □ Positive distemper antigen IFA
Other (explain) :

6. Laboratory results.

Please fax all laboratory results to us along with this form.

Fax to: (213) 481-2375 **2010**
Rev 4/2010 EB