



OFFICE OF LABORATORY SERVICES

Andrea M. Labik, Sc.D. / Director
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PLACE BARCODE HERE
OLS USE ONLY

RABIES LABORATORY SPECIMEN SUBMISSION FORM

SUBMITTER INFORMATION

FACILITY NAME		MAILING ADDRESS		
COUNTY	ATTENTION TO:	CITY	STATE	ZIP
FAX NO.		BUSINESS HOURS PHONE NO.		
		AFTER HOURS PHONE NO.		

Species		If a domestic animal, what is current vaccination status? <input type="checkbox"/> Current <input type="checkbox"/> None <input type="checkbox"/> Expired <input type="checkbox"/> Unknown		DATE COLLECTED	
Date of Animal Death:	How did animal die?		Was the animal buried before brain removal? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Animal Wild or Owned? <input type="checkbox"/> Not Owned/Wild/Stray <input type="checkbox"/> Owned (Name of Owner _____)				Phone # of Owner	
Address Where Found		City		State	Zip
County Where Found		GIS Coordinates Latitude _____ Longitude _____			
Name of Person Sample Received From:			Telephone		
Occupation (check ONE only): <input type="checkbox"/> Animal Control Officer <input type="checkbox"/> Veterinarian <input type="checkbox"/> Police <input type="checkbox"/> Wildlife Officer <input type="checkbox"/> Private Citizen <input type="checkbox"/> County Health Official <input type="checkbox"/> Other _____					
Reason for Testing (Check ALL That Apply): <input type="checkbox"/> Human Exposure <input type="checkbox"/> Other _____				Surveillance: <input type="checkbox"/> Found Dead/Roadkill <input type="checkbox"/> Odd Behavior	
<input type="checkbox"/> Pet/Domestic Animal Exposure (Specify: _____)					

COMPLETE FOR ORAL RABIES VACCINATION PROGRAM ONLY

Animal Number _____ | Data Collected By (County) _____ | Brainstem Specimen Collected By (County) _____

HUMAN EXPOSURE No Yes (If yes, please complete the following:)

Name of Exposed	Address of Exposed	Phone # of Exposed
Exposure Type <input type="checkbox"/> Bite <input type="checkbox"/> Scratch <input type="checkbox"/> Contact Saliva <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____	Location of Wound	Post-Exposure Prophylaxis Started? <input type="checkbox"/> Yes <input type="checkbox"/> No

PET/DOMESTIC ANIMAL EXPOSURE No Yes (If yes, please complete the following:)

Type of Animal Exposed <input type="checkbox"/> Dog <input type="checkbox"/> Cat <input type="checkbox"/> Livestock <input type="checkbox"/> Other _____	Vaccination Status of Exposed Animal <input type="checkbox"/> Current <input type="checkbox"/> Expired <input type="checkbox"/> None <input type="checkbox"/> Unknown
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COMMENTS:

OLS USE ONLY <input type="checkbox"/> UNSAT Reason/ID:	ACC: DE: CKD:
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FAILURE TO COMPLETE THIS FORM IN ITS ENTIRETY MAY RESULT IN DELAYED TEST RESULTS