

Bureau of Laboratories	
110 Pickering Way Lionville, PA 19353	Phone: (610) 280-3464 FAX: (610) 524-2079

(Bureau of Labs Use ONLY)
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Submit Completed Form  
together with Animal Specimen To:

Submitter Specimen Reference ID (if any): \_\_\_\_\_ Date of Death: \_\_\_\_\_ Type of Death:  Natural  Destroyed

Kind of Animal Submitted (Specify): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Indicate whether the animal exhibited any of the following symptoms. Check all that apply.

<input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Loss of Appetite	<input type="checkbox"/> Unusual Viciousness <input type="checkbox"/> Straining	<input type="checkbox"/> Choking <input type="checkbox"/> Wandering from Home	<input type="checkbox"/> Slobbering <input type="checkbox"/> Restlessness & Excitability	<input type="checkbox"/> Sagging Jaw <input type="checkbox"/> Paralysis in Hind Legs
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Human Exposure?  Other Animal Exposure?  County Where incident occurred: \_\_\_\_\_

Please provide any additional information regarding the behavior of the animal and circumstances of exposure:

Was the submitted animal vaccinated against Rabies?  YES  NO  UNKNOWN  
 If the answer is YES, please provide the date of the LAST vaccination: Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Person Bitten or Scratched:**

If multiple victims were involved, enter the number of persons exposed here. Attach additional sheets for each victim.

NAME (Last, First): \_\_\_\_\_ Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ County: \_\_\_\_\_

Area of Body Bitten: \_\_\_\_\_ Scratched: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Owner of Submitted Animal:** (If wildlife use Pennsylvania Game Commission (PGC) contact information)

NAME (Last, First): \_\_\_\_\_ Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ County: \_\_\_\_\_

**NOTE: Results will only be reported by telephone to the Veterinarian, Physician or Health Facility. Phone No. MUST be provided.**

**VETERINARIAN/SUBMITTER Name & Address:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ ext. \_\_\_\_\_

FAX: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Email: \_\_\_\_\_

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RESULTS: \_\_\_\_\_ Codes: \_\_\_\_\_

Contact: \_\_\_\_\_

Facility: \_\_\_\_\_

Phone: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Contact Tech Initials: \_\_\_\_\_ Report Reviewed  Initials: \_\_\_\_\_

Review Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Contact: \_\_\_\_\_

Facility: \_\_\_\_\_

Phone: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Contact Tech Initials: \_\_\_\_\_ Report Reviewed  Initials: \_\_\_\_\_

Review Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**If the victim consulted a PHYSICIAN or HEALTH CARE FACILITY, please provide Name & contact information:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ ext. \_\_\_\_\_

FAX: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Email: \_\_\_\_\_

Contact: \_\_\_\_\_

Facility: \_\_\_\_\_

Phone: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Contact Tech Initials: \_\_\_\_\_ Report Reviewed  Initials: \_\_\_\_\_

Review Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Contact: \_\_\_\_\_

Facility: \_\_\_\_\_

Phone: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Contact Tech Initials: \_\_\_\_\_ Report Reviewed  Initials: \_\_\_\_\_

Review Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_