



WISCONSIN STATE
LABORATORY OF HYGIENE
465 Henry Mall, Madison, WI 53706-1578

Charles D. Brokopp, Dr. P.H., Director
D.F.I. Kurtycz, M.D., Medical Director
CDD Customer Service
608-262-6386
800-862-1013
http://www.slh.wisc.edu

RABIES REQUISITION FORM (7/06) Number: 577 FORM 4110

ST CROIX CO DHHS/PUBLIC HEALTH
Address: (715)246-8263

1445 N 4TH ST
NEW RICHMOND WI 54017-1063

Bill to: 577

1. Reason for Rabies Testing:

- Human Exposure (complete sections 2A, 3, 4, 5)
- Animal Exposure (complete sections 2B, 3, 4, 5)
- Other (complete sections 3, 4, 5)
Specify _____

2. Exposure Information (complete section 2A for human exposure, 2B for animal exposure)

2A. Person Exposed Exposure Date ____/____/____ (If more than one person exposed, complete back of form)

<p>Name _____</p> <p>Address _____</p> <p>City/State/Zip _____</p> <p>Date of Birth _____ Age _____ Sex _____</p> <p>Phone # 1st (____) _____ 2nd (____) _____</p> <p>Type of Exposure:</p> <p><input type="checkbox"/> Bite <input type="checkbox"/> Scratch</p> <p><input type="checkbox"/> Lick <input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> Other _____</p>	<p>Physician (**required**)</p> <p>Name _____</p> <p>Clinic Name _____</p> <p>City/State/Zip _____</p> <p>Physician Phone # (____) _____</p> <p>Post Exposure Treatment:</p> <p>Vaccine <input type="checkbox"/> Yes <input type="checkbox"/> No Date initiated _____</p> <p>HRIG <input type="checkbox"/> Yes <input type="checkbox"/> No Date initiated _____</p> <p>None <input type="checkbox"/></p>
--	--

2B. Animal Exposed Exposure Date ____/____/____ (If more than one animal exposed, complete back of form)

<p>Species _____ Age _____</p> <p>Rabies Vaccination Current? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unkn</p> <p>Type of Exposure:</p> <p><input type="checkbox"/> Bite <input type="checkbox"/> Scratch</p> <p><input type="checkbox"/> Ingestion <input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> Lick <input type="checkbox"/> Other _____</p>	<p>Owner (of exposed animal) _____</p> <p>Address _____</p> <p>City/State/Zip _____</p>
--	---

3, 4 & 5 Specimen Submission Information

<p>3. Specimen Information</p> <p>Species _____ <input type="checkbox"/> Domestic-Owned <input type="checkbox"/> Domestic-Stray/Feral <input type="checkbox"/> Wild <input type="checkbox"/> Unknown</p> <p>Age _____</p> <p>Rabies Vaccination Current? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unkn</p> <p>Date of last vaccination: ____/____/____</p> <p>Vaccine lot _____ Manufacturer _____</p> <p>Animal vaccinated prior to last vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Animal Signs:</p> <p><input type="checkbox"/> Aggressive <input type="checkbox"/> Ataxia <input type="checkbox"/> Convulsion</p> <p><input type="checkbox"/> Depression <input type="checkbox"/> Disorientation <input type="checkbox"/> Frothing</p> <p><input type="checkbox"/> Howling/Bellowing <input type="checkbox"/> Nausea <input type="checkbox"/> Paralyzed</p> <p><input type="checkbox"/> Shallow Respiration <input type="checkbox"/> Other _____</p>	<p>Number of animals submitted for testing: _____</p> <p>Date of Death ____/____/____ <input type="checkbox"/> Died <input type="checkbox"/> Euthanized</p> <p>Owner (of submitted animal) _____</p> <p>Address _____</p> <p>City/State/Zip _____</p> <p>Phone # (____) _____</p>
---	--

4. Veterinarian

<p>Name _____</p> <p>Address _____</p>	<p>Phone # (____) _____</p> <p>City/State/Zip _____</p>
--	---

5. Local Health Department Jurisdiction

WSLH Use only