



VETERINARY PUBLIC HEALTH-RABIES CONTROL PROGRAM

Tel. (213) 989-7060 or 877-747-2243 Fax (213) 481-2375

publichealth.lacounty.gov/vet



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): _____

5. Clinical Findings

Highest body temperature measured _____

Physical Examination

	Normal	Comments
General:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Skin:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Head Area:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Respiratory:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Cardiovascular:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Abdomen/digestive:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Urogenital:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Musculoskeletal:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Nervous:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Lymph nodes:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Other:	<input type="checkbox"/> Yes <input type="checkbox"/> 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.