

Animal # \_\_\_\_\_

**RABIES HISTORY AND SUBMISSION FORM**  
Animal Disease Laboratory, Nevada Department of Agriculture  
405 South 21st Street • Sparks, NV 89431  
Phone: (775)353-3709; Fax: (775)353-3659

**SPECIMEN INFORMATION:** Species: \_\_\_\_\_ Breed: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
Rabies Vaccination:  No  Unknown  Yes If Yes, vaccination expires on: \_\_\_\_\_  
Did the animal show symptoms:  Neurological deficits  Paralysis/Paresis  Aggression  Drooling  
Animal Location (captured or taken into custody): \_\_\_\_\_ Date/Time: \_\_\_\_\_ Observer \_\_\_\_\_  
Euthanasia:  Yes  No Date of death: \_\_\_\_\_ Submission:  Entire  Head  Tissue

**OWNER INFORMATION:**  Wild  Stray  Owned  
Name: \_\_\_\_\_ Address: \_\_\_\_\_ City: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Home Phone:(\_\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_ (optional)

**Human Exposure:**  Yes  No **Bite Number** \_\_\_\_\_ **Total Number of Humans Exposed:** \_\_\_\_\_  
Name: \_\_\_\_\_ Date: \_\_\_\_\_ Phone:(\_\_\_\_\_) \_\_\_\_\_  
Incident Details: \_\_\_\_\_

**Animal Exposure:**  Yes  No Species \_\_\_\_\_ Breed \_\_\_\_\_ Age \_\_\_\_\_  
Rabies Vaccination:  No  Unknown  Yes If Yes, vaccination expires on: \_\_\_\_\_  
Owner: \_\_\_\_\_ Address: \_\_\_\_\_ ZIP: \_\_\_\_\_ Phone:(\_\_\_\_\_) \_\_\_\_\_  
Incident Details: \_\_\_\_\_

**Submitter:**  
Agency/Clinic: \_\_\_\_\_ Name (Officer/individual): \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_

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<b>For ADL use only:</b>	<b>RESULTS:</b>	<b>CREMATION:</b>	<b>REPORTING:</b>
Acc #: _____	Negative: <input type="checkbox"/>	Communal Cremation: <input type="checkbox"/>	Date: _____
Date Received: _____	Positive: <input type="checkbox"/>	Custom Cremation: <input type="checkbox"/>	Time: _____
Time Received: _____	Unsatisfactory: <input type="checkbox"/>	External Cremation: <input type="checkbox"/>	Reported to: _____
Specimen Condition: _____	Weight: _____	Disarticulation: <input type="checkbox"/>	Staff member: _____
Reagent and Lot No.: _____	Exp. Date: _____	Diagnostician Signature (s): _____	
	Exp. Date: _____		
Comment: _____			