VETERINARY PUBLIC HEALTH-RABIES CONTROL PROGRAM
Tel. (213) 989-7060 or 877-747-2243 Fax (213) 481-2375
publichealth.lacounty.gov/vet

County of Los Angeles
Public Health

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

3. Animal Location (where in community animal originated, if not same as owner)

Name(s)
Address
City, ZIP

4. Reporting Veterinary Clinic or Shelter

Name of veterinarian or technician:
Vet Clinic Name:
Address:
City, ZIP:
Telephone Fax E-mail:

5. History

Date of onset of first symptoms_________________ Date of presentation_________________
Date of death(s), if applicable___________________
History (include vaccine history, if applicable):

Fax 2-page form to: (213) 481-2375 or email to vet@ph.lacounty.gov **2013**

5/2013

6. Clinical Findings

Highest body temperature measured___________________

Physical Examination

	Normal		Comments
General:	□ Yes	□ No	______________________
Skin:	□ Yes	□ No	______________________
Head Area:	□ Yes	□ No	______________________
Respiratory:	□ Yes	□ No	______________________
Cardiovascular:	□ Yes	□ No	______________________
Abdomen/digestive:	□ Yes	□ No	______________________
Urogenital:	□ Yes	□ No	______________________
Musculoskeletal:	□ Yes	□ No	______________________
Nervous:	□ Yes	□ No	______________________
Lymph nodes:	□ Yes	□ No	______________________
Other:	□ Yes	□ No	______________________

7. Treatment.

Please describe treatment given, particularly antibacterial, antiviral, antifungal, antiparasitic.

Treatment Date	Describe Treatment
1. ____________	______________________
2. ____________	______________________
3. ____________	______________________

8. Laboratory results

Please fax all laboratory results to us along with this form.

9. Additional comments.

Please use an additional sheet if needed.

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