MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

REQUIRING DOCUMENT: NHCCHASNINST 6320.5	ISSUANCE DATE: 20110407
LOCAL FORM TITLE: CARE OF ANIMAL BITES	

Because animal bites are always heavily contaminated with bacteria, an infection may develop even when proper initial treatment has been given. It is vital that you observe the following:

1. Follow the advice given by your treating Primary Care Manager.

2. Contact your Primary Care Manager at 794-6000 if you notice any of the following:

   (a) Wound becomes red, swollen, tender, and warm

   (b) Wound begins to drain pus

   (c) Red streaks occur up the arm or leg

   (d) Tender lumps appear in the groin or under the arm

   (e) Shaking, chills, or fever

3. Take precautions against rabies: Comply with the submission of animal bite forms. If you were bitten by a pet dog or cat, the owner should be asked to confine the animal for observation. If you were bitten by a wild animal or a stray dog or cat, keep the animal, whenever possible, in your possession until an examination for rabies can be made by Public Health Officials. Treatment for rabies, when necessary, will be arranged through Naval Health Clinic, Charleston. Questions can be directed to the Preventive Medicine Division at 794-6553.

4. If you were given a Tetanus toxoid injection, make a note of the date. Such information may be useful to you in the future. If rabies vaccination prophylaxis is indicated, the following schedule MUST be adhered to. Shot #1 will be administered at initial visit. Shots #2 through #4 will be given in the Immunizations Clinic on an appointment basis (call 794-6850).

SHOT NUMBER	SCHEDULED DATE	DATE ADMINISTERED	PROVIDER'S STAMP AND SIGNATURE
Day 0 - #1	_____	_____	_____
Day 3 - #2	_____	_____	_____
Day 7 - #3	_____	_____	_____
Day 14 - #4	_____	_____	_____

_____
Patient's Signature/Date:

_____
Provider's Stamp/Signature/Date:

_____
Patient's Name:

_____
Patient's Date of Birth:

This information is protected by Privacy Act of 1974 (PL-93-579) and
The Health Insurance Portability and Accountability Act (PL 104-191)

PRACTITIONER'S/NURSE'S NAME	PRACTITIONER'S/NURSE'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
	SPONSOR'S NAME	SSN
	RELATIONSHIP TO SPONSOR	