

**Specimen Request Form for Rabies Testing**  
**WILLIAM A. HINTON STATE LABORATORY INSTITUTE**  
 305 South Street  
 Jamaica Plain, MA 02130-3597  
 Tel. 617-983-6385

[Lab use only]  
  
 Date Received \_\_\_/\_\_\_/\_\_\_

PLEASE PRINT

DO NOT ABBREVIATE

<b>1. PROVIDER/SENDER INFORMATION</b>				<b>2. OWNER INFORMATION (or person who found animal)</b>			
Name _____				Name: Last _____		First _____	
Address: No./Street/Apt.# _____				Address: No./Street/Apt.# _____			
City/Town _____		State _____		City/Town _____		State _____	
Zip Code _____				Zip Code _____			
Phone Number: ( ) _____				Phone Number: ( ) _____			
<b>3. SPECIMEN INFORMATION</b>							
				<input type="checkbox"/> Pet <input type="checkbox"/> Stray <input type="checkbox"/> Wild <input type="checkbox"/> Unknown			
Species _____		Breed _____		Age _____		Death Date ___/___/___	
				Cause of Death: <input type="checkbox"/> Natural <input type="checkbox"/> Euthanized			
Method _____							
<b>Location Where Animal was located:</b>		<b>Symptoms:</b>				<b>Reason for Rabies Testing:</b>	
Street _____		<input type="checkbox"/> Aggression		<input type="checkbox"/> Found Dead		<input type="checkbox"/> Seizures	
Town _____		<input type="checkbox"/> Ataxia		<input type="checkbox"/> Lethargy		<input type="checkbox"/> Unexplained	
		<input type="checkbox"/> Disorientation		<input type="checkbox"/> Paralysis		<input type="checkbox"/> Wound	
		<input type="checkbox"/> Salivation		<input type="checkbox"/> Other _____		<input type="checkbox"/> Human Exposure	
						<input type="checkbox"/> Pet Exposure	
						<input type="checkbox"/> Acting Sick	
<b>Travel Out of State:</b>			<b>Bitten by Another Animal in Past 12 Months:</b>			<b>Vaccination History:</b>	
<input type="checkbox"/> Yes			<input type="checkbox"/> Yes (type of animal _____)			<input type="checkbox"/> Rabies Vaccinated (___/___/___)	
(Location _____ Date ___/___/___)			<input type="checkbox"/> No			<input type="checkbox"/> Not Rabies Vaccinated (not current)	
<input type="checkbox"/> No			<input type="checkbox"/> Unknown			<input type="checkbox"/> Unknown	
<input type="checkbox"/> Unknown							
<b>4. EXPOSURE INFORMATION</b>							
<b>Person(s) Exposed</b>				<b>Animal(s) Exposed</b>			
Exposure Date ___/___/___				Exposure Date ___/___/___			
Name _____				Name _____			
Physician Name _____				Species _____			
Address: No./Street/Apt.# _____				Age _____			
City/Town _____		State _____		City/Town _____		State _____	
Zip Code _____		Zip Code _____		Address: No./Street/Apt.# (if different from owner) _____			
Phone Number: ( ) _____		Physician Phone Number: ( ) _____		City/Town _____		State _____	
Zip Code _____		Zip Code _____		City/Town _____			
State _____		State _____		State _____			
Zip Code _____		Zip Code _____		Zip Code _____			
<b>Type of Exposure:</b>		<b>Body Site</b>		<b>Type of Exposure:</b>		<b>Body Site</b>	
(check one)				(check one)			
<input type="checkbox"/> Bite		<input type="checkbox"/> Bite		<input type="checkbox"/> Bite		<input type="checkbox"/> Bite	
<input type="checkbox"/> Scratch		<input type="checkbox"/> Scratch		<input type="checkbox"/> Scratch		<input type="checkbox"/> Scratch	
<input type="checkbox"/> Lick		<input type="checkbox"/> Lick		<input type="checkbox"/> Lick		<input type="checkbox"/> Lick	
<input type="checkbox"/> Other _____		<input type="checkbox"/> Other _____		<input type="checkbox"/> Other _____		<input type="checkbox"/> Other _____	
<input type="checkbox"/> Unknown		<input type="checkbox"/> Unknown		<input type="checkbox"/> Unknown		<input type="checkbox"/> Unknown	
<b>Circumstance of Exposure:</b>		<b>Severity</b>		<b>Circumstance of Exposure:</b>		<b>Severity</b>	
(check one)				(check one)			
<input type="checkbox"/> Capture		<input type="checkbox"/> Specimen Preparation		<input type="checkbox"/> Fight		<input type="checkbox"/> Fight	
<input type="checkbox"/> Unprovoked Attack		<input type="checkbox"/> Other _____		<input type="checkbox"/> Vicinity		<input type="checkbox"/> Vicinity	
<input type="checkbox"/> Provoked Attack				<input type="checkbox"/> Dead Animal Contact		<input type="checkbox"/> Dead Animal Contact	
<input type="checkbox"/> Handling				<input type="checkbox"/> Other _____		<input type="checkbox"/> Other _____	
<b>Pre-Exposure Vaccination History:</b>		<b>Post-Exposure Rabies Vaccination:</b>		<b>Pre-Exposure Vaccination History:</b>		<b>Post-Exposure Rabies Vaccination:</b>	
<input type="checkbox"/> Rabies Vaccinated (current)		<input type="checkbox"/> Received		<input type="checkbox"/> Rabies Vaccinated (current)		<input type="checkbox"/> Received	
<input type="checkbox"/> Not Rabies Vaccinated (not current)		<input type="checkbox"/> Not Received		<input type="checkbox"/> Not Rabies Vaccinated (not current)		<input type="checkbox"/> Not Received	
<input type="checkbox"/> Unknown		<input type="checkbox"/> Unknown		<input type="checkbox"/> Unknown		<input type="checkbox"/> Unknown	
<b>5. FLUORESCENT RABIES ANTIBODY TEST RESULTS</b>							
				<b>Reported By:</b> _____		<b>Date:</b> ___/___/___ [Lab use only]	
<input type="checkbox"/> Positive (rabid) <input type="checkbox"/> Negative (not rabid) <input type="checkbox"/> Specimen Unsatisfactory				<b>Comments:</b> _____			
<b>Results Read Back By:</b> _____				<b>/Voice Message</b>		<b>Notified By:</b> _____	
						<b>Date:</b> ___/___/___ [Lab use only]	