



Tennessee Department of Health
Division of Laboratory Services
Rabies Submission

**Place State Lab Accession
Label Here
(TDH use only)**

***Indicates required fields**

SPECIMEN COLLECTION INFORMATION		SUBMITTER INFORMATION	
*Kind of Animal:		*Submitting Facility:	Submitter Number:
*Date Specimen Collected:		Address:	
Specimen Collector Name:		City:	County:
Phone Number of Collector: () -		State:	Zip Code:
Animal Collection Site (Address or GPS):		Phone Number: () -	Fax Number: () -
City:	State:	E-mail Address:	
Zip Code:	*County:		
* REASON FOR SUBMISSION (Provide details below)		*PUBLIC HEALTH CONTACT	
<input type="checkbox"/> Person Exposed <input type="checkbox"/> Other Animal Exposed <input type="checkbox"/> Surveillance Program		<input type="checkbox"/> Has a Public Health Official been contacted regarding this submission? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of contact: _____	
Was the attack provoked? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Death: __/__/____	<input type="checkbox"/> Natural Death <input type="checkbox"/> Euthanized	
OWNER OF ANIMAL			
Last Name:		First Name:	Middle Initial:
Address:		Phone Number: () -	
City:	County:	State:	Zip Code:
*PERSON EXPOSED <input type="checkbox"/> YES <input type="checkbox"/> NO			
Last Name:		First Name:	Middle Initial:
<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth: __/__/____		
Address:		Phone Number: () -	
City:	County:	State:	Zip Code:
Date of Exposure: __/__/____	Exposure Type: <input type="checkbox"/> Bite <input type="checkbox"/> Saliva Contact <input type="checkbox"/> Neurological Tissue <input type="checkbox"/> Scratch		
	Exposure Site: <input type="checkbox"/> Arm <input type="checkbox"/> Foot <input type="checkbox"/> Hand <input type="checkbox"/> Head <input type="checkbox"/> Leg <input type="checkbox"/> Throat <input type="checkbox"/> Torso		
*OTHER ANIMAL EXPOSED <input type="checkbox"/> YES <input type="checkbox"/> NO			
Type of Animal Exposed:		Date of Exposure: __/__/____	
Owner Last Name:		Owner First Name:	Owner Middle Initial:
Address:		Phone Number: () -	
City:	County:	State:	Zip Code:
ADDITIONAL SPECIMEN INFORMATION			
Vaccination History:			
List of Clinical Signs:			
Date of First Clinical Signs: __/__/____			
Additional Information:			
LABORATORY FACILITIES		Billing Information (TDH use only)	
<input type="checkbox"/> Nashville Central Laboratory, 630 Hart Lane Nashville, TN 37216 615-262-6350			
<input type="checkbox"/> Knoxville Regional Laboratory, 2101 Medical Center Way Knoxville, TN 37920 865-549-5201			