MOBILE COUNTY HEALTH DEPARTMENT

Referral for service
Rabies Post-Exposure Treatment

DATE	REFERRING HEALTH FACILITY	
PROVIDER NAME	STREET ADDRESS	
CITY, STATE AND ZIP	TELEPHONE	FAX
SIGNATURE AND TITLE OF PROVIDER		DATE OF SIGNATURE

REFERRING TO THE FOLLOWING HEALTH CENTER AT THE MOBILE COUNTY HEALTH DEPARTMENT (CIRCLE ONE LOCATION)

PEDIATRIC HEALTH CENTER PHONE: 251.690.8949 FAX: 251.690.8987	ADULT HEALTH CENTER PHONE: 251.690.8958 FAX: 251.690.8859

PATIENT INFORMATION

PATIENT NAME	STREET ADDRESS
CITY	STATE AND ZIP
BIRTHDATE	SEX MALE FEMALE WEIGHT:
BITE REPORT FORM COMPLETED AND FAXED TO RABIES OFFICE YES NO FAX: 251.690.8953	DATE BITE OCCURRED

ANATOMICAL LOCATION OF BITE(S)

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION ON THE NAMED CLIENT/PATIENT TO THE PROVIDER SPECIFIED ABOVE.

SIGNATURE OF PATIENT/PARENT/GUARDIAN	DATE OF SIGNATURE