

MARINE MAMMAL REHABILITATION DISPOSITION REPORT

FIELD #: _____ NMFS REGIONAL #: _____ NATIONAL DATABASE#: _____
(NMFS USE) (NMFS USE)

COMMON NAME: _____ GENUS: _____ SPECIES: _____

REHABILITATION FACILITY: _____

Address: _____ Phone: _____

| | |
|---|---|
| <p>STRANDING HISTORY</p> <p>Date: Year: _____ Month: _____ Day: _____</p> <p>Sex: <input type="checkbox"/> 1. Male <input type="checkbox"/> 2. Female</p> <p>Straight Length: _____ <input type="checkbox"/> cm <input type="checkbox"/> in <input type="checkbox"/> actual <input type="checkbox"/> estimate</p> <p>Weight: _____ <input type="checkbox"/> kg <input type="checkbox"/> lb <input type="checkbox"/> actual <input type="checkbox"/> estimate</p> | <p>ADMISSION INTO REHABILITATION</p> <p>Date: Year: _____ Month: _____ Day: _____</p> <p>Received From: _____</p> <p>Straight Length: _____ <input type="checkbox"/> cm <input type="checkbox"/> in <input type="checkbox"/> actual <input type="checkbox"/> estimate</p> <p>Weight: _____ <input type="checkbox"/> kg <input type="checkbox"/> lb <input type="checkbox"/> actual <input type="checkbox"/> estimate</p> |
|---|---|

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| <p>MEDICAL RECORD AND SPECIMEN TRACKING</p> <p>Samples collected: <input type="checkbox"/> 1. YES <input type="checkbox"/> 3. Unknown <input type="checkbox"/> 2. NO</p> <p>Pre-release Health Screen: <input type="checkbox"/> 1. YES <input type="checkbox"/> 3. Unknown <input type="checkbox"/> 2. NO</p> <p>Other Specimen Tracking: <input type="checkbox"/> 1. Scientific collection <input type="checkbox"/> 2. Education collection <input type="checkbox"/> 3. Other: _____</p> | <p>Sample Type/Diagnostic Test/Disposition:</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p> <p>4. _____</p> <p>5. _____</p> <p>6. _____</p> <p>7. _____</p> <p>8. _____</p> |
|--|--|

| DISPOSITION (Check one of more) | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|-------|------------------------|--------------------------|--------------------------|---------|---------|-------|--|--|-----------------------|--------------------------|--------------------------|-------|--|--|-----------------------|--------------------------|--------------------------|-------|--|--|-----------------------|--------------------------|--------------------------|
| <p><input type="checkbox"/> 1. Transferred to Another Facility</p> <p>Year: _____ Month: _____ Day: _____</p> <p>Facility: _____</p> <p>Address: _____</p> <p>Comments: _____</p> | <p><input type="checkbox"/> 4. Released</p> <p>Year: _____ Month: _____ Day: _____</p> <p>State: _____ County: _____ City: _____</p> <p>Locality Details: _____</p> <p>Latitude: _____ N</p> <p>Longitude: _____ W</p> <p>Straight Length: _____ <input type="checkbox"/> cm <input type="checkbox"/> in <input type="checkbox"/> actual <input type="checkbox"/> estimate</p> <p>Weight: _____ <input type="checkbox"/> kg <input type="checkbox"/> lb <input type="checkbox"/> actual <input type="checkbox"/> estimate</p> <p>Age Class: _____</p> | | | | | | | | | | | | | | | | | | | | | | | | |
| <p><input type="checkbox"/> 2. Retained following Rehabilitation</p> <p>Year: _____ Month: _____ Day: _____</p> <p>Location: _____</p> <p>Comments: _____</p> <p>I.D.#: _____ (NMFS USE)</p> | <p><input type="checkbox"/> 3. Died</p> <p>Year: _____ Month: _____ Day: _____</p> <p>Location: _____</p> <p>Cause of Death: _____</p> <p>Comments: _____</p> | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>TAG DATA (*D=Dorsal; LF=Left Front; LR=Left Rear; RF=Right Front; RR=Right Rear)</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">I.D.#</th> <th style="text-align: left;">Color</th> <th style="text-align: left;">Type</th> <th style="text-align: left;">Placement (Circle ONE)</th> <th style="text-align: center;">Applied</th> <th style="text-align: center;">Present</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td></td> <td></td> <td style="text-align: center;">D DF L LF LR RF RR</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>_____</td> <td></td> <td></td> <td style="text-align: center;">D DF L LF LR RF RR</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>_____</td> <td></td> <td></td> <td style="text-align: center;">D DF L LF LR RF RR</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table> | | I.D.# | Color | Type | Placement (Circle ONE) | Applied | Present | _____ | | | D DF L LF LR RF RR | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | | D DF L LF LR RF RR | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | | D DF L LF LR RF RR | <input type="checkbox"/> | <input type="checkbox"/> |
| I.D.# | Color | Type | Placement (Circle ONE) | Applied | Present | | | | | | | | | | | | | | | | | | | | |
| _____ | | | D DF L LF LR RF RR | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | |
| _____ | | | D DF L LF LR RF RR | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | |
| _____ | | | D DF L LF LR RF RR | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | |
| <p><small>* D = Dorsal; DF= Dorsal Fin; L = Lateral Body LF=Left Front; LR = Left Rear; RF = Right Front; RR = Right Rear</small></p> | | | | | | | | | | | | | | | | | | | | | | | | | |

