Pathogenes Inc
15471 NW 112th Ave.
Reddick, FL 32686
Siobhan P. Ellison DVM PhD
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Equine Submission and Consultation Form

Test(s) Request

- ☐ ***S. neurona*: SAG 1, 5, 6**
- ☐ **CRP: C-reactive Protein**
- ☐ **Screen: Lyme**
- ☐ **Neurofilament**
- ☐ **Neospora**
- ☐ **Sidewinder: MPP;MP2**
- ☐ ***S. fayeri***
- ☐ **Consider for Field Trial**

VETERINARIAN INFORMATION

Vet Name: _____ **Phone**: _____

Address: _____ Referral: Include my practice for referral _____

City, State, Zip: _____ Email: _____

Vet Signature: _____ **Date**: _____

ANIMAL INFORMATION

Animal Name: _____ Age: _____

Breed, Sex: _____ Weight: _____

ANIMAL EVALUATION

1) Assign a neurologic score: ☐ **0 normal** ☐ **1 light** ☐ **2 mild** ☐ **3 moderate** ☐ **4 severe** ☐ **5 down**

2) *Circle neurologic signs of Polyneuritis equi (PNE) if present (need 4 for trial)*: Tail paresis | Perianal analgesia | Dribbles urine or holds feces | Ear droops | Can't blink | Weakness trips sidewinding

2) What other neurologic deficits were observed? ☐ Behavior ☐ Seizure ☐ Stringhalt ☐ Muscle Atrophy ☐ Cranial Nerve

3) How long has this animal shown signs of EPM? _____/days _____/weeks _____/months

4) Is this animal currently on treatment? ☐ Yes ☐ No

5) Has this animal been previously treated for EPM? ☐ Yes ☐ No

*If **Yes**, select treatment(s):* ☐ Orogin ☐ NeuroQuel ☐ Decoquinate ☐ Marquis ☐ Protazil ☐ Compounded

Treatment dates: _____

PAYMENT INFORMATION

SAG 1, 5, 6 serotype	CRP	Lyme Screen	*S. fayeri*	Neospora	MPP/MP2	Neurofilament
$45	$20	$25	$30	$40	$60	$75

If Owner, please provide phone number and email.

Name on Card: _____ Exp. Date: _____

Credit Card #: _____ CSC #: _____

Billing Address: _____ Billing Zip: _____

To send samples with this form **USPS**: Pathogenes - P. O. Box 970, Fairfield, FL 32634 **RUNS WHEN WE RECEIVE THE SAMPLE**

To send samples with this form through **FedEx** or **UPS**: Pathogenes - 15471 NW 112th Avenue, Reddick, FL 32686

Service Agreement: By submitting this form to Pathogenes, it is considered a retainer for Dr. Siobhan P. Ellison's consultant services. Consulting services will be initiated following the receipt of this submission form with a test sample, signed by the Veterinarian. This agreement entitles you to participate in discussions about the case, the bioassay results, and the clinical signs of disease with Dr. Siobhan P. Ellison. The veterinarian listed above has a valid client patient relationship as defined in 21 CFR 530.3(i).

For Office Use Only		
Lab ID #:	SAG Results:	Date Invoiced:
		Amount Invoiced:
		Payment by: CC ☐ Check ☐