Pathogenes Inc

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Equine Submission and Consultation Form

Test(s) Requested:	☐ EPM: SAG 1, 5, 6	☐ CRP: C-reactive Protein	☐ Screen: Lyme	☐ Neurofilament
	☐ Neospora	☐ Sidewinder: MPP;MP2	☐ *S. fayeri*	

VETERINARIAN INFORMATION

Vet Name: ____________________ **Phone**: ____________________

Address: ____________________ Fax: ____________________

City, State, Zip: ____________________ Email: ____________________

Vet Signature: ____________________ **Date**: ____________________

ANIMAL INFORMATION

Animal Name: ____________________ Age: ____________________

Breed, Sex: ____________________ Weight: ____________________

ANIMAL EVALUATION

Do you observe hypo/hyper aesthesia or abnormal tail carriage? ________________	**Normal** No Signs	**Light** Deficit	**Mild** Deficit	**Moderate** Deficit	**Severe** Deficit	**Recumbent** & Unable to rise
1) Assign a neurologic **Gait Assessment Score**:	☐ **0**	☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**

2) What 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 cerebrospinal fluid (CSF) available? ☐ Yes ☐ No

5) Is Lyme disease on the diagnosis list? ☐ Yes ☐ No

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

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

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

Treatment date: ___________ ___________ ___________ ___________ ___________

Compounded treatment: ____

PAYMENT INFORMATION

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

Name on Card: ____ Exp. Date: ________________

Credit Card #: ____ CSC #: ________________

Billing Address: ____ Billing Zip: ________________

Send this form with sample: 2-day mail (USPS) to: Pathogenes - PO Box 970, Fairfield, FL 32634
2-day mail (FedEx) to: Pathogenes - 15471 NW 112th Ave, 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 ☐