

### Equine Submission and Consultation Form

**Test(s) Requested:**

<input type="checkbox"/> <b>S neurona:</b> SAG 1, 5, 6	<input type="checkbox"/> <b>CRP: C-reactive Protein</b>	<input type="checkbox"/> <b>Screen: Lyme</b>	<input type="checkbox"/> <b>Neurofilament</b>
<input type="checkbox"/> <b>Neospora</b>	<input type="checkbox"/> <b>Sidewinder: MPP;MP2</b>	<input type="checkbox"/> <b>S. fayeri</b>	<input type="checkbox"/> <b>LPS</b> Consider for field study

#### 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 &amp; 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

Circle PNE signs: Sidewinding Trips Weak Tail paresis Perianal analgesia Dribbles urine Holds feces Ear droop Can't blink

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):  Oroganin     NeuroQuel     Decoquinate     Marquis     Protazil

Treatment date: \_\_\_\_\_

 Compounded treatment 

#### PAYMENT INFORMATION

SAG 1, 5, 6	CRP	Lyme Screen	S. fayeri	Neospora	MPP/MP2	NfL	LPS
\$50	\$28	\$30	\$35	\$45	\$65	\$75	\$55

Name on Card: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Credit Card #: \_\_\_\_\_ CSC #: \_\_\_\_\_

Billing Address: \_\_\_\_\_ Billing Zip: \_\_\_\_\_

**OWNER PHONE:** \_\_\_\_\_ **OWNER EMAIL:** \_\_\_\_\_

Send this form along with sample to:

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/Amount Invoiced:
		Payment by: CC <input type="checkbox"/> Check <input type="checkbox"/>