



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: _____ Fax: _____
 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 sidwinding |
|--------------|--------------------|-------------------------------|------------|-------------|---------------------------|
- 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 Decoquinatate 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

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 <input type="checkbox"/> Check <input type="checkbox"/>