



Pathogenes Inc

15471 NW 112th Ave.
Reddick, FL 32686

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Test(s) Requested:	<input type="checkbox"/> EPM: SAG 1, 5, 6	<input type="checkbox"/> CRP: C-reactive Protein	<input type="checkbox"/> Screen: Lyme
	<input type="checkbox"/> Neospora	<input type="checkbox"/> Sidewinder: MPP; MP2	<input type="checkbox"/> S. Fayeri

VETERINARIAN INFORMATION

Vet Name: _____ **Date:** _____
 Address: _____ Phone: _____
 City, State, Zip: _____ Phone: _____
Vet Signature: _____ Fax: _____

ANIMAL INFORMATION

Animal Name: _____ Age: _____
 Breed: _____ Weight: _____

ANIMAL EVALUATION

	Normal No Signs	Light Deficit	Mild Deficit	Moderate Deficit	Severe Deficit	Recumbent & Unable to rise
1) Assign a neurologic Gait Score:	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
2) What neurologic deficits were observed?	<input type="checkbox"/> Behavior <input type="checkbox"/> Seizure <input type="checkbox"/> Stringhalt <input type="checkbox"/> Muscle Atrophy <input type="checkbox"/> Cranial Nerve					
3) How long has this animal shown signs of EPM?	_____ /days		_____ /weeks		_____ /months	
4) Is cerebrospinal fluid (CSF) available?	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
5) Is Lyme disease on the diagnosis list?	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
6) Is this animal currently on treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
7) Has this animal been previously treated for EPM?	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
If Yes , select treatment(s):	<input type="checkbox"/> Orogin <input type="checkbox"/> NeuroQuel <input type="checkbox"/> Decoquinatate <input type="checkbox"/> Marquis <input type="checkbox"/> Diclazuril					
Treatment date:	_____					

PAYMENT INFORMATION

	SAG 1, 5, 6	CRP	Lyme Screen	S. Fayeri	Neospora	MPP/MP2
Prepaid Price by <u>Check</u> :	\$38	\$20	\$25	\$30	\$40	\$60
Price by <u>Credit Card</u> :	\$45					

Credit Card #: _____ Exp. Date: _____
 Billing Address: _____ Billing Zip: _____

Send this form 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

For Office Use Only			
Lab ID #:	Results:	Results:	Email Phone Fax
		Invoiced:	
		Payment:	Check CC