Pathogenes Inc

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

VETERINARIAN INFORMATION

Vet Name: _____ **Date**: _____

Address: _____ Phone: _____

City, State, Zip: _____ Email: _____

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**:	☐ **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 ☐ Diclazuril

Treatment date: _____ _____ _____ _____ _____

PAYMENT INFORMATION

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

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Lab ID #:	Results:	Results: Email Phone Fax
		Invoiced:
		Payment: Check CC