



Pathogenes Inc

15471 NW 112th Ave.
Reddick, FL 32686

Siobhan P. Ellison DVM PhD

Phone: (352) 591-3221
Fax: (352) 591-4318

Request:

- EPM: SAG 1, 5, 6
- CRP: C-reactive protein
- Screen: Lyme
- Vitamin E
- 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: _____ Weight: _____

ANIMAL EVALUATION

	Normal No Signs	Light Deficit	Mild Deficit	Moderate Deficit	Severe Deficit	Recumbent & Unable to rise
1) Assign a neurologic Gait Assessment 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"/> Protazil					
Treatment date:	_____					

Compounded treatment: _____

PAYMENT INFORMATION

SAG 1, 5, 6	CRP	Lyme Screen	S. fayeri	Neospora	MPP/MP2	Vitamin E
\$45	\$20	\$25	\$30	\$40	\$60	\$40/ \$50

Name on Card: _____ Exp. Date: _____

Credit Card #: _____ CSC #: _____

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

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 #:	Results:	Invoiced:
		Check #: _____ Amt: _____