Pathogenes Inc

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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

Check here if you observe hypo/hyper aesthesia or abnormal tail carriage: ☐

1) Assign a neurologic **Gait Assessment Score**:	**Normal** No Signs	**Light** Deficit	**Mild** Deficit	**Moderate** Deficit	**Severe** Deficit	**Recumbent** & Unable to rise
	☐ **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 ☐ 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: