



# Pathogenes Inc

15471 NW 112<sup>th</sup> Ave.  
Reddick, FL 32686

Siobhan P. Ellison DVM PhD

Phone: (352) 591-3221

Fax: (352) 591-4318

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

### VETERINARIAN INFORMATION

Vet Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ Fax: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_ Email: \_\_\_\_\_  
 Vet Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### ANIMAL INFORMATION

Animal Name: \_\_\_\_\_ Age: \_\_\_\_\_  
 Breed: \_\_\_\_\_ Weight: \_\_\_\_\_

### ANIMAL EVALUATION

Do you observe hypo/hyper aesthesia or abnormal tail carriage?

	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 <input type="checkbox"/>						

### PAYMENT INFORMATION

SAG 1, 5, 6	CRP	Lyme Screen	<i>S. fayeri</i>	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: 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 #:	SAG Results:	Date Invoiced:
		Amount Invoiced:
		Payment by: CC <input type="checkbox"/> Check <input type="checkbox"/>