Pathogenes Inc

15471 NW 112th Ave
Reddick, FL 32686

Siobhan P. Ellison DVM PhD
Phone: (352) 591-3221
Fax: (352) 591-4318

Biopsy Sample

Vet Name ______________________ Phone: ______________
Address ______________________ Fax: ______________
City, State, Zip ______________________ eMail: ______________
Vet Signature ______________________ Date: ______________

ANIMAL INFORMATION

Animal Name: ____

Age: ______ Breed: ________________ Weight: __________

1) Circle a neurologic Gait Assessment Score:

Normal No Signs 0	Light Deficit 1	Mild Deficit 2	Moderate Deficit 3	Severe Deficit 4	Recumbent Unable to rise 5

2) Circle neurological deficits that were observed

Behavior	Seizure	Stringhalt	Muscle Atrophy	Cranial Nerve

3) How long has this animal neurologic impairment: _________days _____________weeks ___________months

4) Is cerebrospinal fluid (CSF) available? ☐ Yes ☐ No

5) Is this animal currently on treatment? ☐ Yes ☐ No

6) Did the animal respond to treatment? ☐ Yes ☐ No

7) Has this animal been previously treated for EPM? ☐ Yes ☐ No

What EPM treatment was used?	Orogin	NeuroQuel	Decoquinate	Marquis	Protazil	Compounded medication
Date used	_______	_______	_______	______	_______	________

Comments:

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:	