### Test(s) Requested:
- EPM: SAG 1, 5, 6
- Neospora
- CRP: C-reactive Protein
- Sidewinder: MPP;MP2
- Screen: Lyme
- Vitamin E
- S. fayeri

#### VETERINARIAN INFORMATION
- Vet Name: __________
- Phone: __________
- Address: __________
- Fax: __________
- City, State, Zip: __________
- Vet Signature: __________
- Email: __________
- Date: __________

#### ANIMAL INFORMATION
- Animal Name: __________
- Age: __________
- Breed: __________
- Weight: __________

#### ANIMAL EVALUATION
1. **Do you observe hypo/hyperesthesia or abnormal tail carriage?**
   - Yes [ ]
   - No [ ]

2. **Assign a neurologic Gait Assessment Score:**
   - Normal No Signs [ ]
   - Light Deficit [ ]
   - Mild Deficit [ ]
   - Moderate Deficit [ ]
   - Severe Deficit [ ]
   - Recumbent & Unable to rise [ ]

3. **What neurologic deficits were observed?**
   - Behavior [ ]
   - Seizure [ ]
   - Stringhalt [ ]
   - Muscle Atrophy [ ]
   - Cranial Nerve [ ]

4. **How long has this animal shown signs of EPM?**
   - ________/days
   - ________/weeks
   - ________/months

5. **Is cerebrospinal fluid (CSF) available?**
   - Yes [ ]
   - No [ ]

6. **Is Lyme disease on the diagnosis list?**
   - Yes [ ]
   - No [ ]

7. **Is this animal currently on treatment?**
   - Yes [ ]
   - No [ ]

8. **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** $45
- **CRP** $20
- **Lyse Screen** $25
- **S. fayeri** $30
- **Neospora** $40
- **MPP/MP2** $60
- **Vitamin E** $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 §30.3(i).

* * * * *

For Office Use Only
- **Lab ID #:** __________
- **SAG Results:** __________
- **Date Invoiced:** __________
- **Amount Invoiced:** __________
- **Payment by:** CC [ ]
- **Check** [ ]