Pathogenes Inc

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Test(s) Requested:			
☐ EPM: SAG 1, 5, 6	☐ CRP: C-reactive Protein	☐ Screen: Lyme
☐ IFAT: *S. Neurona*	☐ 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**:	☐ 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 ☐ Diclazuril

Treatment date: _____ _____ _____ _____ _____

PAYMENT INFORMATION

SAG 1, 5, 6	CRP	Lyme Screen	S. Fayeri	IFAT	MPP; MP2
$45	$20	$25	$30	$50	$60

Credit Card #: _____ Exp. Date: _____

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

For Office Use Only		
Lab ID #:	Results:	Invoiced:
		Check #: Amt: