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| **ANIMAL SPECIMEN SUBMISSION FORM MA STATE PUBLIC HEALTH LABORATORY**  **305 SOUTH STREET, jamaica plain, MA 02130-3597**  PLEASE PRINT **TEL: 617-983-6200**  DO NOT ABBREVIATE | | | | | | DDDD Do not use this space | |
| 1. SEND RESULTS TO : Facility/Veterinarian  Full Address  Phone number : ( ) | | | 2. OWNER / ANIMAL INFORMATION : Owner’s Name and Full Address  Phone ( )  If applicable, stable / farm name and address  Animal Name / ID | | | | |
| 3. CONTACT INFORMATION:Name | | | **4. Sex** M F  CM  SF | | | | 5. AGE **Breed** |
| Phone Number: ( ) | | | DATE OF ONSET OF SYMPTOMS: \_\_\_\_ / \_\_\_\_\_ /\_\_\_\_\_ | | | | |
| **6. TEST(s) REQUESTED:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Reason:  Symptomatic  Die off  Surveillance Confirmation Necropsy  Presumptive ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Clinical Information:  Meningitis  Unsteady gait Encephalitis Muscle WeaknessMuscle Tremors  Paralysis  Alive Dead Euthanized  Date of death: \_\_\_\_ /\_\_\_\_\_/ \_\_\_\_\_\_ | | | 7. SPECIES: | AVIAN  OVINE  BOVINE  PORCINE  CANINE  PRIMATE  CAPRINE  REPTILE  EQUINE  \_\_\_\_\_\_\_\_\_\_\_\_\_  FELINE | | | |
|
| 8. FOR SEROLOGY: Serum  Spinal Fluid (CSF) Acute  Convalescent  Late Convalescent    Date Collected \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ | | | | |
|
| 9. FOR CULTURE: Specimen submitted is: (Please check one)  Original Material  Subculture (complete both dates on line below)Complete these dates: Original Material Collected: \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ Subculture made: \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ | | | | | | | |
| **10. SOURCE OF ORIGINAL MATERIAL / SUBCULTURE:**  **Has specimen been preserved?** No  Yes, Specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | **11. VACCINATIONS:** | | |
| Blood (whole) | Fecal |  | | | **1st Dose (Mo/Yr) 2nd Dose (Mo/Yr)** | | |
| Brain | Plasma | Wound (site) | | | EEE/WEE | | |
| Cloacal | Serum | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | \_\_\_\_/ \_\_\_\_ \_\_\_\_/ \_\_\_\_ | | |
| CSF | Urine | Other (specify**)** | | |  | | |
|  |  | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | WNV | | |
| Tissue (specify)  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | Isolate (site) | | | **\_\_\_\_/ \_\_\_\_ \_\_\_\_/ \_\_\_\_** | | |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |  | | |
| **12. EPIDEMIOLOGICAL INFORMATION:** | | | | | | | |
| Symptoms, Date of Onset and Duration\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Travel History with dates (include in- and out-of-state)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Human/Animal/Arthropod Contact (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Previous Laboratory Results**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other Relevant Vaccinations (give dates) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Additional Information:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | |

**INSTRUCTIONS**: If a section does not apply to a given situation, write N/A (not applicable). For more information on testing, see the Manual of Tests and Services at <http://www.mass.gov> Search: manual lab