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| **ANIMAL SPECIMEN SUBMISSION FORMMA 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/VeterinarianFull AddressPhone number : ( ) | 2. OWNER / ANIMAL INFORMATION :Owner’s Name and Full AddressPhone ( )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 Weakness **[ ]** Muscle 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