



MDA Animal Health Laboratories

Frederick Animal Health Laboratory
 1840 Rosemont Avenue, Frederick, MD 21702
 Phone: (301) 600-1548 / Fax: (301) 600-6111
 Email: ahfrederick.mda@maryland.gov

Salisbury Animal Health Laboratory
 27722 Nanticoke Road, Unit 3, Salisbury, MD 21801
 Phone: (410) 543-6610/ Fax: (410) 543-6676
 Email: ahsalisbury.mda@maryland.gov

EQUINE SERVICE REQUEST FORM

Payment Method:
 Credit Card Cash Check #: _____ Bill Vet

Amount: \$ _____

Accession #: _____

What state is the animal located in? _____**What county is the animal located in?** _____

Owner: _____

Farm Identity: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Phone: _____ Fax: _____

Report Distribution: Email Fax USPS No Report

Vet/Agent: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Phone: _____ Fax: _____

Report Distribution: Email Fax USPS No Report**Provide Necropsy Pictures with Report:** YES NO**Animal Location same as Owner:** YES NO; **Provide Address:** _____

| | Animal Name: | Tattoo #: <small>(Provide Anatomical Location)</small> | Microchip #: <small>(Provide Anatomical Location)</small> | Breed: | Age: | Gender: | Origin of Animal <small>Purchase Date & Location</small> |
|----|--------------|-----------------------------------------------------------|--------------------------------------------------------------|--------|------|---------|-----------------------------------------------------------------|
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Reason for test: Diagnostic Neurological Insurance Claim (Complete "Authorization to Release Information to Insurance Company" Form)**Specimen Submitted:** Carcass Serum EDTA Whole Blood Heparinized Whole Blood Feces CSF EDTA Plasma Heparinized Plasma Swab (Provide anatomical location): _____ Other: _____**Date Sample Collected:** _____**TEST REQUESTED:** _____

Total # of Animals on premise: _____ # Sick Animals: _____ # Dead Animals: _____

Date & Time of Death: _____ Found Deceased Euthanized, Agent/Method Used: _____Recent Diagnostic Testing: Blood work ECG Scoping Ultrasound Radiographs Other: _____

Please provide details: _____

Date of Negative EIA Test: _____ Previous DNA Testing: _____

Recent Illnesses: Colic Overheating Lung/Nasal Bleeding Slow to cool down after exercise Lameness
 Heart Murmur Arrhythmia Exercise Intolerance Upper airway noise when exercising Other: _____

Illness Duration: _____

Travel History w/in last 30 days: YES NO If so, where: _____Exposure to new &/or traveling horses: YES NO If so, describe events & give locations; _____

Medications (List all including supplements): _____

Vaccinations (Include dates): Rabies: _____ EEE/WEE/TET: _____ WNV: _____ Flu/Rhino: _____ Other: _____

Diet: Grain (Type & Amount Fed): _____ Hay (Type & Amount Fed): _____

Other Supplements (Type & Amount): _____

*Continue on next page**Continue on next page*



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EQUINE SERVICE REQUEST FORM (Continued)

Accession #: _____

Diseases to Rule Out: _____

History:

Multiple horizontal lines for text entry.

FOR LABORATORY USE ONLY

CARCASS WEIGHT: _____ LBS /KG/G