



Frederick Animal Health Laboratory

1840 Rosemont Avenue
Frederick, MD 21702

Phone: (301) 600-1548 Fax: (301) 600-6111
Email: ahfrederick.mda@maryland.gov

EQUINE SERVICE REQUEST FORM

Payment Method: _____ Amount: _____ Date Rec'd: _____ Staff Initials: _____ Accession #: _____

What State Is The Animal Located In? _____

What County Is The Animal Located in? _____

Owner: _____

Farm Identity: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Phone: _____ Fax: _____

Report Distribution: E-Mail _____ Fax _____ USPS _____ No Report _____

Vet/Agent: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Phone: _____

Fax: _____

Report Distribution: E-Mail _____ Fax _____ USPS _____ No Report _____

Animal Location same as Owner: Yes _____ No; *Provide Address:* _____

Tattoo #:

Microchip #:

(Provide Anatomical Location)

(Provide Anatomical Location)

Breed:

Age:

Gender:

Origin of Animal
Purchase Date & Location:

1)

2)

3)

4)

5)

6)

7)

8)

9)

10)

Reason for test: Diagnostic _____ Neurological _____ Insurance Claim (please 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:** _____

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

Time of Death: _____

Recent Diagnostic Testing: Blood work _____ ECG _____ Scoping _____ Ultrasound _____ Radiographs _____ Other: _____

Please provide details: _____

Date of Negative EIA Test: _____

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: _____

Previous DNA Testing: _____

Travel history w/in last 30 days: Yes _____ No _____ If so, where? _____

Exposure to new horses &/or traveling horses: Yes _____ No _____ If so, describe events and 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): _____

Diseases to Rule Out: _____



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EQUINE SERVICE REQUEST FORM *(Continued)*

ACCESSION #

Clinical Signs:

FOR LABORATORY USE ONLY
NECROPSY WORKSHEET

BACTI / MYCO	SPECIMEN	PARASITOLOGY
<input type="checkbox"/> ROUTINE <input type="checkbox"/> SALMONELLA <input type="checkbox"/> LISTERIA <input type="checkbox"/> CLOSTRIDIUM		<input type="checkbox"/> CRYPTO <input type="checkbox"/> GIARDIA <input type="checkbox"/> McMASTER <input type="checkbox"/> OCCULT BLOOD

SEROLOGY	RESULTS	VIROLOGY / FA	RESULTS	PCR	RESULTS
<input type="checkbox"/> EIA		<input type="checkbox"/> RABIES		<input type="checkbox"/> EHV-1	
		<input type="checkbox"/> ROTA		<input type="checkbox"/> Influenza A	