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
Provide Necropsy Pictures with Report: Yes No

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:* _____________________________

	Animal Name:	Tattoo #: (Provide Anatomical Loation)	Microchip #: (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: ____

Continue on next page

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EQUINE SERVICE REQUEST FORM *(Continued)*

ACCESSION #______________________

Clinical Signs:

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FOR LABORATORY USE ONLY

NECROPSY WORKSHEET

BACTI	SPECIMEN	PARASITOLOGY
☐ AEROBIC	Lung Liver Kidney Placenta Other:	☐ McMASTER
☐ ANAEROBIC	Lung Liver Kidney Placenta Other:	☐ OCCULT BLOOD
☐ SALMONELLA	Feces Intestine Intestinal Contents Fetal Tissue Pooled: Lung, Liver, Stomach Content	☐ FECAL BAERMAN (Lungworm)
☐ CLOSTRIDIUM	Intestine Intestinal Contents	
☐ LISTERIA	Brain Stem Fetal Tissue Pooled: Lung, Liver, Stomach Content	

SEROLOGY	RESULTS	VIROLOGY / FA	RESULTS	PCR	RESULTS
☐ EIA		☐ RABIES		☐ EHV-1	
		☐ ROTA		☐ IAV (Equine)	
		☐ CRYPTO			
		☐ GIARDIA			