



State of New Jersey Department of Agriculture Division of Animal Health

PO Box 330, Trenton, NJ 08625 www.state.nj.us/agriculture

NEUROLOGIC WORKSHEET

Division Telephone: (609) 671-6400

Fax: (609) 671-6414

(Specimens submitted for testing become property of the laboratory and may be tested as part of Federal or State surveillance programs. Please contact the laboratory to discuss if private cremation of animal remains is desired.)

Veterinarian Name:		Address:		,			
Telephone #:							
Fax #:							
Animal Owner's Name			Owner's Phone #:				
	-	OCATION	OF ANIMA	ΔI			
Stable/Farm Name:			Street Address:				
Animal's Travel History:		City/Municip	oality:	County:			
			Zip Code:				
Name of Animal:							
Circle appropriate info:	male neutered male	female p	oregnant fema	ale immature male i	mmature female		
Age:			Breed:				
Color:			ID (Tattoo, tag, brand, etc):				
Status of Animal (circle a	ppropriate info)						
Alive	Died Date of death:		Euthanized Date euthanized:				
Date of Onset of Illness:			Date of Initia	al Veterinary Examination	:		
Circle Signs Observed:	front ataxia	eating grain		rear ataxia	quad ataxia		
hindlimb weakness	agitation	hypersensitiv	ity	aggression	inability to rise		
muscle fasciculation	anorexia	disorientation		hypermetria	stumbling/falling		
excessive sweating	circling	apprehension		volcalization	teeth grinding		
eating hay	star gazing	depression		other:			
Circle Types(s) of Treatment:		DMSO		corticosteroids	fluids		
		banamine		bute	anti-serum		
		antibiotics		other:			

Name of Animal:							
Laboratory Specimens Collected (circle appropriate info): Date Specimens Collected:		blood	brain	other:			
		Lab to which specimen(s) sent:					
	VACCINA	TION HIST	ORY				
Is animal vaccinated (p		No	Unknown				
Vaccination:	Vaccination Given by: (circle appropriate info)						
EWT		vet	owner	other:	, , , , , , , , , , , , , , , , , , ,		
Rabies		vet	owner	other:			
Rhino		vet	owner	other:			
EPM		vet	owner	other:			
ВОТ		vet	owner	other:			
Other:		vet	owner	other:			
WNV	Date of Initial Vaccination:	vet	owner	other:			
WNV	Date of 2nd dose of initial series:	vet	owner	other:			
WNV	Date of Booster:	vet	owner	other:			
Brand Name of WNV	Product Used:						
	Cirolo ann	rangiata anau					
Circle appr Does the animal have any possible bite wounds?		Yes	ers:	No			
Have humans been bitten or exposed to saliva?		Yes		No			
If yes, how many peop	le were exposed?						
Is the animal isolated from other animals?		Yes		No			
Has a local health department been notified?		Yes		No			
If yes, what county?							
Are there other animals at this location?		Yes		No			
If yes, please list species and number of each species:		Species:_			Number:		
Species:	Number:	Species:_			Number:		
Are any of the other animals sick?		Yes		No			
If yes, please list species and number sick:		Species:_			Number:		
Species:	Number:	Species:			Number:		