

State of New Jersey Department of Agriculture Division of Animal Health Lab Use Only

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.)

programe. The deb contact are laboratory to alcoude in private cremation of animal remains to desired.				
Veterinarian Name:	Address:			
Telephone #:				
Fax #:				
Animal Owner's Name	Owner's Phone #:			

LOCATION OF ANIMAL									
			Street Address:						
Animal's Travel History:			City/Munici	pality:	County:				
			Zip Code:		-				
Name of Animal:									
Circle appropriate info:	male neutered male	female	pregnant fem	ale immature male	immature female				
Age:			Breed:						
Color:		ID (Tattoo, tag, brand, etc):							
Status of Animal (circle a	appropriate info)								
Alive	Died Date of death:	Euthanized Date euthanized:							
Date of Onset of Illness: Date of Initial Veterinary Examination:					on:				
Circle Signs Observed:	front ataxia	eating grain		rear ataxia	quad ataxia				
hindlimb weakness	agitation	hypersensitivity		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	blood	brain	other:		
Date Specimens Colle	Lab to which specimen(s) sent:				
	VACCINA	TION HIST	ORY		
Is animal vaccinated (pl	lease circle one): Yes	No	Unknown		
Vaccination:	Date of Vaccination:	Vaccination Given by: (circl			le 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 F	Product Used:				
	Circle ann	ropriate ansv	vers:		
Does the animal have a	any possible bite wounds?	Yes		No	
Have humans been bitten or exposed to saliva?		Yes		No	
If yes, how many people	e 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	
f yes, please list species and number of each species:		Species:_			Number:
Species:	Number:	Species:_			Number:
Are any of the other ani	mals sick?	Yes		No	
If yes, please list species and number sick:		Species:_			Number:
Species:	Number:	Species:_			Number: