Equine Arbovirus Testing Form

Maryland Department of Health and Mental Hygiene
Laboratories Administration
201 West Preston Street, Baltimore, MD 21201
Phone: 410-767-6153

Name of person completing form: _____

Phone # of person completing form: (____) _____ Date form completed: ____/____/____

Veterinarian Information PLEASE PRINT LEGIBLY IN ALL SECTIONS OF THIS FORM

Name: _____

Mailing address: _____

City: _____ State: _____ Zip: _____

Office phone: _____ Mobile phone: _____

Fax number: Email address:

Animal Information *MANDATORY* (*Specimen will not be tested without complete contact information)*

Name of Horse: _____ Age: _____

Breed: _____ Gender: (Circle One) Mare Filly Gelding Colt Stallion

Address where stabled: _____

City: _____ State: _____ County: _____ Zip: _____

Owner's name: Owner's phone:

Animal History

WNV vaccine: Yes No Date given: #1: ___/___/____ #2: ___/___/____ Booster: ___/___/____

EEE vaccine: Yes No Date given: #1: ___/___/____ #2: ___/___/____ Booster: ___/___/____

Rabies vaccine: Yes No Date last given: ___/___/____

Travel history (within last 30 days): Yes No If so, where? _____ Date: ___/___/____

Exposure to new horses and/or traveling horses? Yes No Describe events and give locations: _____

Are any other horses on the farm exhibiting neurologic clinical signs? Yes No

Describe: _____

Clinical Information

Date of onset of neurologic clinical signs: / /

Describe clinical signs: (circle all that apply)				
	Altered mentation	Depression	Listlessness	Recumbency/inability to stand
	Apprehension	Fever (Temp: _____)	Muscle fasciculations	
	Ataxia	Flaccid paralysis of lower lip	Other: _____	
	Blindness	Head shaking	Paralysis	

Concurrent illness: Yes No Unknown If yes, describe clinical signs/diagnosis: _____

Vital status: Alive Dead Euthanized Date of death: / / Unknown

Testing Information *A separate testing form must accompany EACH specimen*

Date specimen collected: ____/____/____ Specimen: Blood Brain Other _____

Test: PCR (fresh brain **ONLY; NO formalin-fixed tissues)** IgM capture ELISA

For Laboratory Use Only

Lab Accession #: _____ Date received: _____/_____/_____

Comments: _____