Illinois Department of Agriculture
Animal Disease Lab, Galesburg
2100 South Lake Storey Road
Galesburg, Illinois 61401
(309) 344-2451 Fax 344-7358

Send Results by: ☐ Mail ☐ Fax ☐ Email

Accession #

Clinic Name _____
Veterinarian _____
Clinic/Vet ID _____
Address _____
_____
City_____ ST _____ Zip _____
Phone ( ) _____ Fax _____
Email address:_____

Owner _____
Address _____
City _____ State _____
County _____ Zip _____
Phone _____
Email _____
Location of animals
City _____ County _____
State _____ Zip _____
Premises ID:_____

ANIMAL INFORMATION: Species: _____ Breed: _____ Age: _____
Wt.: _____ Sex: ☐M ☐F ☐NM ☐SF Animal ID (name, tag #): _____
☐ Euthanized? If so what method _____ Hours between death and necropsy: _____
Sick: _____ # Dead: _____ # in Group: _____ # on Premises: _____ Duration of Problem: _____

HOUSING: ☐ Household ☐ Kennel ☐ Confinement ☐ Pastured ☐ Feedlot ☐ Stabled
☐ Farrowing ☐ Nursery ☐ Grower ☐ Finisher Other: _____

PRESENTING COMPLAINT OR SYNDROME (Please indicate the primary clinical problem(s) in the animal(s) submitted)

☐ Abortion	☐ Musculoskeletal	☐ Respiratory	☐ Unthriftiness
☐ Skin	☐ Neurologic	☐ Tumor/Neoplasia	☐ Urinary
☐ Diarrhea/Enteric	☐ Reproductive	☐ Unexpected death	☐ Other _____

BRIEF HISTORY/DIFFERENTIAL DIAGNOSES (More room on back)_____
_____

SPECIMENS SUBMITTED: Whole animals/carcasses: #Live_____ #Dead_____ #Fetuses_____

	#Refrig		#Refrig		#Refrig	#Fixed		#Refrig	#Fixed		#Refrig	#Fixed
Blood, whole	_____	Serum *	_____	Brain	_____	_____	Liver	_____	_____	Skin biopsy	____	_____
Feces	_____	Stom conts	_____	Heart	_____	_____	LN, mes	_____	_____	Spleen	_____	_____
Feed/water	_____	Thor fluid	_____	Intest, lg	_____	_____	LN, other	_____	_____	Tonsil	_____	_____
Milk	_____	_____	_____	Intest, sm	_____	_____	LN, resp	_____	_____	Tumor	_____	_____
Ocular fluid	_____	_____	_____	Kidney	_____	_____	Lung	_____	_____	_____	_____	_____

*Please use serology form L4 for animals not described on this form.

TESTS REQUESTED: (Unless *Discretion of lab* is marked, ONLY indicated tests will be done. Additional boxes may be marked for special consideration.)

☐ Discretion of the laboratory	☐ Bacterial culture_____	☐ Virology_____
☐ Necropsy ☐ Gross only	☐ Save isolates_____	☐ Serology _____
☐ Histopathology	☐ Fungal culture_____	☐ Toxicology_____
☐ Clin Path _____	☐ Parasitology _____	☐ _____

Owner's, agent's, or veterinarian's signature _____ Date _____

ADDITIONAL HISTORY: (Clinical signs, necropsy findings, treatment and response, antibiotic use, lab results, etc.)

_____

_____

_____

_____

_____

_____

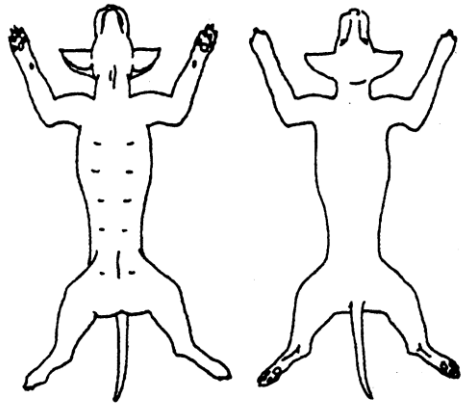
_____

_____

_____

_____

BIOPSY SPECIMEN/SURGICAL PATH



Indicate the location of ALL biopsy sites on the anatomical diagram above. Use A, B, C, etc. to indicate each site and add additional information on the chart to the right.

Tumor A	Tumor B	Tumor C
Location	Location	Location
Size, shape	Size, shape	Size, shape
Color, texture, encapsulation	Color, texture, encapsulation	Color, texture, encapsulation
Expansile, invasive, pedunculated	Expansile invasive, pedunculated	Expansile, invasive, pedunculated
Duration	Duration	Duration
Growth rate	Growth rate	Growth rate
Margins submitted?	Margins submitted?	Margins submitted?
Recurrence?	Recurrence?	Recurrence?
Previous accession number	Previous accession number	Previous accession number

SPECIMENS FOR RABIES EXAMINATION

ANIMAL INFORMATION: Species: _____ Breed: _____ Color:_____

Age: _____ Wt.: _____ Animal ID (name, tag #): _____ Sex: ☐M ☐F ☐NM ☐SF

☐ Animal died? ☐ Killed/euthanatized? Clinical signs/Comments:_____

_____

Owner_____

Address _____

City _____ County _____

State _____ Zip _____

Phone (_____) _____

☐ Human exposure?

Exposed _____

Address _____

City _____ County _____

State _____ Zip _____

Phone (_____) _____