



Equine Encephalitis/Central Nervous System Disorders - Supplemental Information Form

Clemson Veterinary Diagnostic Center and SC Department of Health and Environmental Control
PO Box 102406, Columbia, SC 29224-2406

Phone: (803) 788-2260

Fax: (803) 699-8910

HORSE INFORMATION:

Location: County _____ City/Town _____ Zipcode _____
Specific Location (Street Address): _____ <small>(If not a street address, provide detailed directions. If necessary, please draw a map to the location on the reverse side of this form).</small>
Coordinates: W- _____ (X:longitude) N- _____ (Y:Latitude)
Signalment and History:
Horse Name: _____ Breed: _____ Color: _____ Age: _____ Gender: _____
Significant History including travel: _____
Vaccination Status of Animal: <input type="checkbox"/> Not Vaccinated <input type="checkbox"/> Vaccinated <input type="checkbox"/> Vaccination Status Unknown
If Vaccinated: <input type="checkbox"/> EEE/WEE/TET <input type="checkbox"/> EHV <input type="checkbox"/> WNV <input type="checkbox"/> Rabies Date Vaccinated: _____
Date of Onset of Clinical Signs: _____ Date Examined by Veterinarian: _____
Clinical Signs: _____
Treatment Provided: _____
Sample(s) Taken: _____ Date Taken: _____
Samples Sent to: _____ Date Sent: _____
Status of Animal: <input type="checkbox"/> Recovered <input type="checkbox"/> Died <input type="checkbox"/> Euthanized Date: _____
Other Horses on Premises: <input type="checkbox"/> Yes <input type="checkbox"/> No Other Horses with Similar Signs: <input type="checkbox"/> Yes <input type="checkbox"/> No

OWNER INFORMATION:

Owner Name: _____	Mailing Address (If Different): _____
Street Address: _____	_____
City: _____ State _____ Zip _____	City: _____ State _____ Zip _____
Home Phone Number: () _____	Work Phone Number () _____

VETERINARIAN INFORMATION:

Veterinarian Name: _____	Clinic Name: _____
Vet/Clinic Address: _____	Clinic Phone: () _____
City: _____ State _____ Zip _____	Clinic Fax: () _____

LABORATORY INFORMATION:

CVDC Case # _____ DHEC Case# _____ Date Received: _____
Testing Performed: <input type="checkbox"/> DFA <input type="checkbox"/> IgM ELISA <input type="checkbox"/> PCR <input type="checkbox"/> HP <input type="checkbox"/> Virus Isolation <input type="checkbox"/> Other _____
Diagnosis: <input type="checkbox"/> EEE <input type="checkbox"/> WNV <input type="checkbox"/> Rabies <input type="checkbox"/> Other _____ <input type="checkbox"/> No Definitive Dx
Comments: _____