

**AQUATIC HEALTH ACCESSION FORM**

**Washington Animal Disease Diagnostic Laboratory**

College of Veterinary Medicine, Washington State University

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Please type or use black ink and print clearly.

Veterinarian or Case Coordinator:		WADDL VET CLIENT #:	
		WADDL CLINIC CLIENT #:	
Clinic:			
Street:			
City:	State:	Zip:	
Phone:	Fax:		
Date Shipped:	E-mail:		

WADDL USE ONLY

Owner:	WADDL OWNER CLIENT #:
Street:	
City:	State: Zip:
Phone:	Fax/E-mail:

Please fill out completely as possible:

Specimen(s) Submitted	Sampling Date:
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Aquatic Tests Requested:	<input type="checkbox"/> Necropsy	<input type="checkbox"/> Virology	<input type="checkbox"/> Bacteriology	<input type="checkbox"/> PCR	Antibiotic of interest: _____
	<input type="checkbox"/> Histopathology	<input type="checkbox"/> Fungal culture	<input type="checkbox"/> Parasitology	<input type="checkbox"/> Antibiotic Sensitivity	_____
	<input type="checkbox"/> Toxicology	<input type="checkbox"/> Mycobacteria culture	<input type="checkbox"/> Whirling Disease	<input type="checkbox"/> Other	_____

Note: WADDL reserves the right to modify the tests requested for more efficient case work-up and / or send specimens to outside laboratories to perform tests not done at WADDL.

Species	Animal ID (name/tag#) or Lot #	Water Temperature	Animal Weight	Age	
Location of Lesion(s)	No. in group	No. Dead	No. Sick	No. on Premises	Duration of Problem

\* Was animal euthanized? If so, what method?

Water: <input type="checkbox"/> Marine / Brackish <input type="checkbox"/> Freshwater	System: <input type="checkbox"/> Flow-through <input type="checkbox"/> Recirculating <input type="checkbox"/> Net pen	Other: _____	Health Testing <input type="checkbox"/>	Diagnostic Testing <input type="checkbox"/>	Pathogen(s) of interest: _____
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Additional History: *Vaccinations, signs, stress factors, treatments, post mortem findings, pertinent feed or feed additives, clinical lab results, previous WADDL Case Numbers. (Attach additional sheets as necessary.)*

SAMPLE COLLECTOR: \_\_\_\_\_

Print Collector's Name Collector's Signature

Veterinarian's or Clinician's Signature:	Condition(s) Suspected:
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