

AQUATIC HEALTH ACCESSION FORM

Washington Animal Disease Diagnostic Laboratory

College of Veterinary Medicine, Washington State University

Mailing address:
PO Box 647034
Pullman, WA. 99164-7034

Web Site: <http://waddl.vetmed.wsu.edu>

Shipping address:
1940 SE Olympia Ave
Pullman, WA. 99164-7034

Phone: (509) 335-9696
FAX: (509) 335 7424
E-Mail: waddl@vetmed.wsu.edu

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: _____ Antibiotic Sensitivity _____ Other _____
	<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. Samples submitted become the property of WADDL and may be disposed of in 30 days.

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: <input type="checkbox"/> Health Testing <input type="checkbox"/> Diagnostic Testing	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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