

Farm Animal PME Submission Form

WVSC No:

CLIENT'S NAME AND ADDRESS

PLEASE COMPLETE ALL SECTIONS

Date received:

VETERINARY PRACTICE

Address where animals kept, if different from above

Clinician:
Mobile No.

CPHH No.

Your reference:

ANIMAL DETAILS

SPECIES:

BREED:

SEX: Male Female Castrate Mixed Unknown

AGE: * Delete as appropriate
* Days/Weeks/Months/Years
Please complete age category box below

Neonatal (<1 week) Pre-weaned Post-weaned
Adult Mixed Unknown

PURPOSE/HUSBANDRY Please enter the main enterprise under which the affected animals are kept

Organic production: Yes No Not known

Cattle	Sheep	Pig	All classes	All classes	All classes
Dairy <input type="checkbox"/>	Hill <input type="checkbox"/>	Breeding <input type="checkbox"/>	Captive or zoo <input type="checkbox"/>	Dairy (small ruminant) <input type="checkbox"/>	Other farmed (eg. rabbit, fish, deer) <input type="checkbox"/>
Suckler <input type="checkbox"/>	Lowland <input type="checkbox"/>	Rearing <input type="checkbox"/>	Wild <input type="checkbox"/>	Unknown <input type="checkbox"/>	Pet <input type="checkbox"/>
Beef finisher <input type="checkbox"/>	Lamb finisher <input type="checkbox"/>	Finishing <input type="checkbox"/>	Fibre <input type="checkbox"/>		N/A <input type="checkbox"/>
Calf rearer <input type="checkbox"/>					

REASON FOR SUBMISSION

Diagnostic Is this the first sample from this case/outbreak Yes No Previous Lab. Refs

Monitoring Other (please state)

CLINICAL HISTORY

No. in herd/flock	No. in affected group	No. affected including dead	No. died
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

DURATION OF CLINICAL SIGNS

0-3 days Unknown
4 days – 2 weeks N/A
> 2 weeks

HOUSING

Housed
Outdoors
Mixed
Unknown

CLINICAL SIGNS Please rank in order of importance e.g.1 = main clinical sign

Abortion <input type="checkbox"/>	Milk drop <input type="checkbox"/>	Wasting <input type="checkbox"/>	Recumbent <input type="checkbox"/>	Urinary <input type="checkbox"/>	Healthy <input type="checkbox"/>
Repro – not abortion <input type="checkbox"/>	Malaise <input type="checkbox"/>	/poor condition <input type="checkbox"/>	Found dead <input type="checkbox"/>	Nervous signs <input type="checkbox"/>	N/A <input type="checkbox"/>
Clinical mastitis <input type="checkbox"/>	Diarrhoea <input type="checkbox"/>	Lameness <input type="checkbox"/>	Respiratory <input type="checkbox"/>	Eye disease <input type="checkbox"/>	Other <input type="checkbox"/>
Sub-clinical mastitis <input type="checkbox"/>	GIT – not diarrhoea <input type="checkbox"/>	Musc/Skel – not lar e <input type="checkbox"/>	Skin <input type="checkbox"/>	Unknown <input type="checkbox"/>	

WRITTEN CLINICAL HISTORY

Please also use Supplementary Submission Form

ANIMAL IDENTIFICATION Please also use Supplementary Submission Form

Date animal died:

Official animal ID	Sample ID	Type and number of carcasses
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>



CLINICAL SIGNS (continued)

Written clinical history – include management details, diet, dates of illness/deaths, treatments, vaccination status etc.

ANIMAL AND SAMPLE IDENTIFICATION

Please use the Ancillary Submission Form for additional animal/sample identification

Official animal ID	Sample ID	Type and number of carcasses/samples