

Accession Form
(Complete front and back of form)

One Premise and Species per Accession Form

UK UNIVERSITY OF KENTUCKY
College of Agriculture

Livestock Disease Diagnostic Center
1490 Bull Lea Rd.; PO BOX 14125
Lexington, KY 40512-4125
Phone: (859) 253-0571 Fax: (859) 255-1624
Web: www.lddc.uky.edu

FOR LAB USE ONLY

Labs: C B M/D N P S T V J R
Case Coordinator: _____
Carrier: M We Wa U F O V Other
Rec. Date/Time: _____
Condition: _____

Veterinarian: _____
Clinic Name : _____
Address: _____
City _____ ST _____ ZIP _____
Phone #: (_____) _____
Other: _____
Vet License # _____ Code _____

Owner/Mgr: _____
Farm: _____
Address: _____
City _____ ST _____ ZIP _____
Phone #: (_____) _____
County: _____ Premise ID: _____

NECROPSY ANIMALS ONLY:

Estimated Value of Dead Animals: _____

Animal ID/Name*	Species	Breed	Color	Sex	Neutered	Age	Circle	Wt.
				Male	Yes		Hr Day	
				Female	No		Wk Mon Yr	

Purpose of Test: (Circle) Diagnostic Regulatory Surveillance Export (Country: _____) Research Prepurchase/Sale Other _____

Specimen Information*: (Circle Specimen Type Below)- **DATE/TIME Collected:** _____

Carcass	Tissue:	FIXED	FRESH	Blood, EDTA	Feces	Fluid Type:
	Fetus	Site /Source(s): _____			Blood, Whole	Milk
Placenta	Fixative Type: _____			Serum	Urine	Other: _____
	Complete Diagram on back of form					

History of Illness:

Duration of Illness: _____ (Circle: Hrs, Days, Wks) #Sick animals: _____ #Dead: _____ # in Group:* _____ # on Farm: _____

Primary Findings: (Circle all that apply)

Date/Time of Death: _____

Respiratory	Digestive	Muscle/Skeletal	Fever	Eye	Renal	Reproductive	Abortion
Lethargic	Skin	Central Nervous System	Blood/Circulatory/Cardiovascular	Ear	Found Dead	Other:	

History (Clinical Signs): _____

_____ *Attach additional history*

Vaccination(s): _____
Nutrition, Environment, other Mgmt.: _____

Treatment(s): _____
Response(s): _____
Antibiotics within past 72 hrs? **Yes** or **No** Type: _____

Any previous submissions for this problem? If **YES**, Clinical Diagnosis(es): _____
Accession # _____ Date: _____

*Multiple submissions from same premise require **Accession Continuation Form**.

Veterinarian Signature: _____ **Date:** _____

TEST SELECTION (Complete history required on front of form.)

<p align="center">Necropsy</p> <p>Death Date: _____ AM or PM</p> <p><input type="checkbox"/> Necropsy and related testing</p> <p><input type="checkbox"/> Neurologic (Spinal Cord Removal)</p> <p>Was animal euthanized? Yes or NO If YES, Agent: _____</p> <p><input type="checkbox"/> Rabies Suspect</p> <p>Animal Insured? <input type="checkbox"/> Yes or <input type="checkbox"/> No (Complete bottom of form if insured).</p>	<p align="center">Biopsy</p> <p>Neoplasm: Size (L) ___ x(W) ___ x (D) ___ cm</p> <p>Shape: _____</p> <p>Attachment: _____</p> <p>Tissue Involved: _____</p> <p>Gross Appearance: _____</p> <p>Consistency: _____</p> <p>Color: _____</p> <p>Duration: _____</p> <p>Development Rate: _____</p>		<p align="center">Cytology (Check Source)</p> <p><input type="checkbox"/> Peritoneal Fluid</p> <p><input type="checkbox"/> Synovial Fluid: <i>Site:</i> _____</p> <p><input type="checkbox"/> Pleural Fluid</p> <p><input type="checkbox"/> CSF</p> <p><input type="checkbox"/> Transtrach wash</p> <p><input type="checkbox"/> FNA-<i>Site:</i> _____</p> <p><input type="checkbox"/> Impression Smear: <i>Site:</i> _____</p> <p><input type="checkbox"/> Other _____</p> <hr/> <p align="center">Virology</p> <p><input type="checkbox"/> Virus Isolation-Source: _____</p> <p><input type="checkbox"/> Other: _____</p> <p align="center"><i>*(Submit specimen in SC or SVT)</i></p>
<p align="center">Bacteriology</p> <p>Specify source(s) on front of form</p> <p><input type="checkbox"/> Aerobic Culture & Susceptibility</p> <p style="padding-left: 20px;"><input type="checkbox"/> Screen for Strep equi</p> <p style="padding-left: 20px;"><input type="checkbox"/> Screen for Salmonella</p> <p><input type="checkbox"/> Anaerobic Culture</p> <p style="padding-left: 20px;"><input type="checkbox"/> Screen for C. perfringens</p> <p><input type="checkbox"/> Fungal/Mycology Culture</p> <p><input type="checkbox"/> Johne's Culture</p> <p><input type="checkbox"/> Mastitis Culture – Mastitis (Bovine)</p> <p><input type="checkbox"/> Mycoplasma Culture</p> <p><input type="checkbox"/> Other: _____</p> <p align="center"><i>*(Submit in SC and TM)</i></p>	<p align="center">Clinical Pathology</p> <p><input type="checkbox"/> CBC (L)</p> <p><input type="checkbox"/> Bile Acids: Resting or PP _____ (R)</p> <p><input type="checkbox"/> Electrolytes (Na,K,CL) (R)</p> <p><input type="checkbox"/> Fibrinogen (Indirect Inflammation Indicator)</p> <p><input type="checkbox"/> Chemistry Panel (Species Specific) (R)</p> <p><input type="checkbox"/> Chemistry Panel- System: Renal, Hepatic, Pancreatic (R)</p> <p><input type="checkbox"/> Fluid Analysis: see CYTOLOGY above</p> <p><input type="checkbox"/> Fecal Cryptosporidia</p> <p><input type="checkbox"/> Fecal Parasite Exam</p> <p><input type="checkbox"/> Giardia antigen</p> <p><input type="checkbox"/> Urinalysis (SC-urine)</p> <p><input type="checkbox"/> Urolith/Stone Analysis</p> <p><input type="checkbox"/> Other: _____</p>		<p align="center">Toxicology</p> <p><input type="checkbox"/> Anticoagulants</p> <p><input type="checkbox"/> Blood lead</p> <p><input type="checkbox"/> Cyanide</p> <p><input type="checkbox"/> Ethylene Glycol</p> <p><input type="checkbox"/> GC/MS –unknown substance</p> <p><input type="checkbox"/> Ionophores</p> <p><input type="checkbox"/> Metals (copper, iron, lead, zinc, others)</p> <p><input type="checkbox"/> Mycotoxin Panel</p> <p><input type="checkbox"/> Nitrates/Nitrites</p> <p><input type="checkbox"/> Selenium</p> <p><input type="checkbox"/> Water Panel (pH, TDS, anions)</p> <p><input type="checkbox"/> Other: _____</p>

**R=Red Top L=Lavender (EDTA) SC=Sterile Container SVT = Swab In Viral Transport Media TM = Transport Media*

BOVINE	EQUINE	CANINE/FELINE	CAPRINE/OVINE
<input type="checkbox"/> Anaplasmosis	<input type="checkbox"/> Leptospirosis (MAT) Screen	<input type="checkbox"/> Brucella canis	<input type="checkbox"/> CAE
<input type="checkbox"/> Coronavirus (EM) (feces)	<input type="checkbox"/> Influenza	<input type="checkbox"/> Blastomycosis	<input type="checkbox"/> OPP
<input type="checkbox"/> Bluetongue	<input type="checkbox"/> Potomac Horse Fever (IFA)	<input type="checkbox"/> Histoplasmosis	<input type="checkbox"/> Leptospirosis (MAT)
<input type="checkbox"/> Bovine Leukemia Virus	<input type="checkbox"/> Strep. Equi PCR (swab/wash)	<input type="checkbox"/> Coombs (Canine)	<input type="checkbox"/> Bluetongue
<input type="checkbox"/> Brucellosis*	<input type="checkbox"/> Vesicular Stomatitis	<input type="checkbox"/> FeLV	<input type="checkbox"/> Johne's ELISA
<input type="checkbox"/> BVD	<input type="checkbox"/> West Nile IgM Ab ELISA	<input type="checkbox"/> FIV/FeLV	<input type="checkbox"/> Other: _____
<input type="checkbox"/> IBR	<input type="checkbox"/> Rotavirus LA (feces)	<input type="checkbox"/> Heartworm	PORCINE
<input type="checkbox"/> BRSV	<input type="checkbox"/> Lawsonia PCR (feces)	<input type="checkbox"/> Toxoplasmosis	<input type="checkbox"/> PRV
<input type="checkbox"/> BVD PI (ear notch/serum)	<input type="checkbox"/> Eq.Rhinopneumonitis 1 SN	<input type="checkbox"/> Leptospirosis	<input type="checkbox"/> PRRS
<input type="checkbox"/> Leptospirosis	<input type="checkbox"/> EHV PCR Type 1	<input type="checkbox"/> Lyme Disease	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Neospora caninum	<input type="checkbox"/> EHV PCR Type 4	<input type="checkbox"/> Other _____	AVIAN**
<input type="checkbox"/> Rotavirus LA (feces)	<input type="checkbox"/> PHF PCR	OTHER SPECIES	<input type="checkbox"/> Avian Influenza
<input type="checkbox"/> Johne's ELISA	<input type="checkbox"/> Other _____	_____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Other _____			**NPIP use separate form

**For Regulatory Tests-EVA, EIA, CEM or Brucellosis – Use special forms*

REQUIRED INFORMATION FOR INSURANCE CASES

- Complete information regarding species, breed, sex, age and animal identification is complete on front of form. List any additional identification such as tattoo numbers: _____
- Is this animal insured? Circle: YES or NO. If YES, NAME of Insurance Company: _____
- Can information related to this case be released by LDDC to the insurance company? Circle: YES or NO

Required Signature of Owner or Representative _____

Title _____

Date _____