



Gas Leak Area Animal Disease - Special Surveillance Form

Date form completed _____

On October 23, 2015, a leak of natural gas began at the Aliso Canyon Natural Gas Storage Facility just north of the Porter Ranch area in Los Angeles County. This form is intended to gather information on animals that may potentially have experienced clinical signs after exposure to substances associated with the gas leak. Please inform the pet owner that you are submitting this report to Public Health.

1. Animal Information

Type of animal involved: Dog Cat Fish Bird Other _____

Name _____ Breed _____

Color _____ Sex _____

Age _____ IMPOUND # _____ (if at a shelter)

2. Animal Owner (if applicable)

Name(s)
 Telephone:

3. Animal's location in area near gas leak

Name(s)
 Address
 City, ZIP

Was the animal relocated after the gas leak started to another area? YES NO

If Yes, new city/area where relocated: _____

Date relocated: _____

4. Reporting Veterinary Clinic or Shelter

Name of veterinarian or technician:
 Vet Clinic / shelter name :
 Address:
 City, ZIP:
 Telephone: _____ Fax _____

5. Presentation

Initial presenting complaint: _____

Date of onset of first symptoms _____

Date of presentation _____

Date of death(s), if applicable _____

6. History

a. When living in the gas leak area, was the animal primarily kept indoors or outdoors?

Was the animal left unattended outside?

b. Relevant past clinical diagnoses: (Ex. history of prior gastrointestinal disease, asthma, other respiratory disease, ocular disease, etc prior to gas leak)

c. Was the animal on any medications before presentation? If yes, please list:

d. If the animal was relocated out of the area, did its condition improve after relocation?

e. Other relevant history

7. Physical Exam Findings

Highest body temperature measured _____

	Abnormal?	Describe Signs
General:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Skin:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Head Area:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Respiratory:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Cardiovascular:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Abdomen/digestive:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Urogenital:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Musculoskeletal:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Nervous:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Lymph nodes:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

8. Treatments Please describe any treatments given, and response to treatment:

9. Laboratory results Please include all relevant laboratory results with this form.

10. Additional comments Please use an additional sheet if needed.