Animal Disease/Death Reporting Form
(if the disease you are reporting has a specific form, ideally use that form instead)

Date form completed __________

SUSPECTED DISEASE/CONDITION BEING REPORTED: ________________________________

### 1. Animal Information

<table>
<thead>
<tr>
<th>Type of animal involved:</th>
<th>Domestic Pet</th>
<th>Livestock</th>
<th>Wild animal</th>
<th>Exotic</th>
<th>Zoo animal</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Number of animals:</th>
<th>One</th>
<th>Multiple</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Species of Animal</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Other Identifying Information:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Breed</th>
<th>Color</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Sex</th>
<th>Name</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>IMPOUND #</th>
</tr>
</thead>
</table>

### 2. Animal Owner (if applicable)

Name(s)
Address
City, ZIP
Telephone:

Is it okay for Public Health to call the owner(s) to ask more about the history?  □ YES  □ NO

### 3. Animal Location (where in community animal originated, if not same as owner)

Name(s)
Address
City, ZIP

### 4. Reporting Veterinary Clinic or Shelter

Name of veterinarian or technician:
Vet Clinic Name:
Address:
City, ZIP:
Telephone:  Fax:  E-mail:

### 5. History

Date of onset of first symptoms _________________  Date of presentation _________________

Date of death(s), if applicable _________________

History (include vaccine history, if applicable):

p. 1 of 2

Fax 2-page form to: (213) 481-2375  2013
6. Clinical Findings

Highest body temperature measured___________________

Physical Examination

<table>
<thead>
<tr>
<th></th>
<th>Normal</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>General:</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Skin:</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Head Area:</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Respiratory:</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Cardiovascular:</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Abdomen/digestive:</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Urogenital:</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Musculoskeletal:</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Nervous:</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Lymph nodes:</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Other:</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
</tbody>
</table>

7. Treatment

Please describe treatment given, particularly antibacterial, antiviral, antifungal, antiparasitic.

<table>
<thead>
<tr>
<th>Treatment Date</th>
<th>Describe Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ____________</td>
<td>____________________</td>
</tr>
<tr>
<td>2. ____________</td>
<td>____________________</td>
</tr>
<tr>
<td>3. ____________</td>
<td>____________________</td>
</tr>
</tbody>
</table>

8. Laboratory results

Please fax all laboratory results to us along with this form.

9. Additional comments

Please use an additional sheet if needed.
## Canine Brucellosis Reporting Form

### 1. Dog

<table>
<thead>
<tr>
<th>Name</th>
<th>Breed</th>
<th>Sex/Neut</th>
<th>Age</th>
</tr>
</thead>
</table>

### 2. Dog Owner

Name(s):
Street:
City, ZIP:
Telephone:
Is it okay for Public Health to call the owner(s) to ask more about the history? YES NO

### 3. Reporting Veterinarian

Name of veterinarian or technician:
Vet Clinic Name:
Address:
City, ZIP:
Telephone Fax E-mail:

### 4. Exposure History

- How long has the owner had the dog? 
- Where did the owner get the dog? Please list name and address of animal shelter/rescue group/breeder/private party.
- If this dog is spayed/neutered, please note the approximate date of the procedure.
- Are there any other dogs in the household? YES NO 
- Do any other dogs in the household have the same clinical signs? YES NO
- Has the dog ever mated with another dog (intentional breeding or not)? YES NO
  (If YES, please fill out another form for the dog with which it mated.)
- Has this dog ever been in contact with cattle, goats, sheep, pigs, deer, or rodents? YES NO
  If YES, please describe.
- Is there any known illness in humans that handled the dog? YES NO

### 5. Clinical Findings

Date of onset of first symptoms Date of presentation 
Date of death (if applicable) 
Highest body temperature measured 
Check all that apply: 
- no clinical signs 
- fever 
- lethargy 
- exercise intolerance 
- urinary tract infection 
- abortion 
- diskospondylitis 
- epididymitis 
- ocular lesions 
- enlarged lymph nodes. Node locations: 
- other

### 6. Laboratory results

Please fax all laboratory results to us along with this form.

Fax to: (213) 481-2375 2013
**Coccidioidomycosis Report Form**

<table>
<thead>
<tr>
<th>Date form completed</th>
<th></th>
</tr>
</thead>
</table>

**1. Animal**
- □ Dog □ Cat □ Horse □ Llama □ Other ________________________________
- Name___________________Breed___________________________________Sex/Neut__________Age_________

**2. Animal Owner**
- Name(s):
- Street:
- City, ZIP
- Telephone:
- Is it okay for Public Health to call the owner(s) to ask more about the history? □ YES □ NO

**3. Reporting Veterinarian**
- Name of veterinarian or technician:
- Clinic Name:
- Address:
- City, ZIP:
- Telephone Fax E-mail:

**4. Exposure History**
- Lives primarily outdoors (more than 50% of time) □ Yes □ No
- Digs in soil frequently □ Yes □ No
- Lives within site of earth excavation □ Yes □ No
- Lives on a dirt road □ Yes □ No
- In dust storm within 2 months before illness. □ Yes □ No
- Traveled outside Los Angeles County in 2 months before illness □ Yes □ No
- If Yes, please check areas of travel
  - □ Southern California (outside of LA County)
  - □ Central California/San Joaquin Valley
  - □ Other U.S. State:________________________
  - □ Mexico or Central /South America

**5. Clinical Findings**
- Date of onset of first symptoms__________________Date of presentation__________________
- Date of death (if applicable)___________________
- Highest body temperature measured ____________________________
- Check all that apply: □ Cough □ Fever □ Weight loss □ Lameness
- □ Enlarged lymph node(s) □ Eye lesions □ Pneumonia/Pulmonary
- Anatomic location of lesions:________________________

**6. Treatment**
- (drug, duration):
- Potential drug resistance seen? Explain:

**7. Laboratory results**
- Please fax all laboratory results to us along with this form.

Fax form and lab results to: (213) 481-2375

Rev 3/2014 EB
Heartworm Report Form

Date form completed ____________

1. Pet □ Dog □ Cat
   Name________________________Breed________________________Sex/Neut__________Age__________

2. Pet Owner
   Name(s):
   Street:________________________________________________________
   City, ZIP
   Telephone:
   Is it okay for Public Health to call the owner(s) to ask more about the history? □ YES □ NO

3. Reporting Veterinarian
   Name of veterinarian or technician:
   Vet Clinic Name:________________________________________________________
   Address:________________________________________________________
   City, ZIP:________________________________________________________
   Telephone__________Fax__________E-mail:

4. Exposure History
   Exposure/travel outside of Los Angeles County? □ Yes □ No
   Location and approximate dates:________________________________________________________
   On heartworm preventative before diagnosis? □ Yes □ No (preventative:______________________)
   If Yes, what do you suspect is the cause of prevention failure
   □ Drug resistance □ Irregular dosing □ Other. Explain________________________

5. Clinical Findings
   Date of onset ____________Date of presentation________________
   Date of death________________
   Clinical Signs (check all that apply)
   □ None □ Cough □ Fatigue □ Heart failure
   □ Other _______________________________
   Thoracic radiographs taken? □ Yes □ No
   Comment on radiograph findings:_____________________________________________________

6. Tests and Treatment
   Heartworm blood test date Test (Ag, Ab, microfilaria) Test Result
   1. ____________________________ ____________________________ ____________________________
   2. ____________________________ ____________________________ ____________________________
   3. ____________________________ ____________________________ ____________________________
   Treatment Date Treatment
   1. ____________________________ ____________________________ ____________________________
   2. ____________________________ ____________________________ ____________________________
   3. ____________________________ ____________________________ ____________________________
Canine Hemorrhagic Gastroenteritis (HGE) Reporting Form

Overview: In the winters of 2004, 2005, 2006, and 2008 seasonal outbreaks of mild to moderately severe bloody diarrhea in dogs in LA County were reported to this office. As of yet, no clear cause of the seasonality of this condition has been uncovered. Please continue to report cases.

Date form completed __________

1. Dog Information
   Name ___________________________ Breed ___________________________ Sex ______
   Age ________________ Color ________________

2. Dog Owner
   Name(s) __________________________
   Address __________________________
   City, ZIP __________________________
   Telephone: ________________________
   Is it okay for Public Health to call the owner(s) to ask more about the history? □ YES □ NO

3. Reporting Veterinarian
   Name of veterinarian or technician: __________________________
   Vet Clinic Name: __________________________
   Address: __________________________
   City, ZIP: __________________________
   Telephone: ________________________ Fax: __________________________ E-mail: __________________________

4. Clinical Course
   a. Date of onset of first symptoms____________________ b. Date of presentation____________________
   c. Date of death(s), if applicable _____________________
   d. Fever? YES NO If yes, highest temperature detected = ________________
   e. Clinical Signs (check all that apply):
      □ Anorexia □ Diarrhea-watery □ Diarrhea - mucoid
      □ Lethargy □ Diarrhea – soft stool □ Other clinical signs (list):
      □ Vomiting □ Diarrhea – bloody
      □ Diarrhea - tarry/black stool
   f. Already recovered as of date form filled out? □ YES □ NO □ UNKNOWN
   g. Rate of recovery if known (circle one):
      □ Fast (1-2 days)
      □ Slow (3-5 days)
      □ Very Slow (6+ days)
      □ Waxing and Waning – no clear recovery
      □ No recovery – chronic illness or euthanized/died
### 5. Exposure/Possible Causes

| a. Did dog have any exposure to raw fish (especially Salmon or trout)? □ YES □ NO |
| b. Did the ill dog tend to eat dropped fruit or berries from trees in the environment? □ YES □ NO |
| c. Current brands of dry and canned dog food being fed: __________________________ |
| d. Current type, brands of treats (dry biscuits, jerky treats, rawhide, etc) __________________________ |
| e. Dietary indiscretion by dog in week before onset (i.e trash, swallowed a toy, etc)? □ YES □ NO |
| f. Dog’s regular diet changed in the week before onset? □ YES □ NO |
| g. Any humans in the house have (or recently had) similar symptoms? □ YES □ NO |
| h. Any other dogs, cats, or other pets in the home have similar symptoms? □ YES □ NO |
| i. Any traveling with dog in the week before illness onset? □ YES □ NO |
| j. Does dog leave its property regularly (walks, escapes)? □ YES □ NO |
| k. Does dog have regular access to wildlife or feces/urine from wildlife? □ YES □ NO |
| l. Does owner/veterinarian have any theories about the cause of the dog’s illness? □ YES □ NO |

m. EXPLAIN. If there was a YES answer to any of the above questions, please use the space below to explain:

### 6. Treatment

| a. IV fluids administered? □ YES □ NO |
| b. Subcutaneous fluids administered? □ YES □ NO |
| c. Medications. Please LIST the names of all drugs (antibiotics, antiparasitics, antidiarrheals, etc) used and route of administration (IV, PO, SQ etc). You do not need to note the dose or frequency of use. |

### 7. Laboratory results

| a. In-house Parvo SNAP test result: □ Negative □ Positive □ Not done |
| b. In-house fecal testing (type of test, result) ____________________________________________ |

| c. Please FAX all laboratory results to us along with this form. |

---

Fax to: (213) 481-2375  
2013
Imported Animal Illness or Death Reporting Form

Animals that were recently imported from another country may be ill from diseases that are not common in Los Angeles County. Your reports help detect and limit the spread of imported diseases.

**Date form completed**

<table>
<thead>
<tr>
<th>1. Animal</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Species</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Animal Owner</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name(s):</td>
<td>Street:</td>
</tr>
<tr>
<td>Is it okay for Public Health to call the owner(s) to ask more about the history?</td>
<td>YES</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Reporting Veterinarian</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of veterinarian or technician:</td>
<td>Vet Clinic Name:</td>
</tr>
<tr>
<td>Address:</td>
<td>City, ZIP:</td>
</tr>
<tr>
<td>Telephone:</td>
<td>Fax:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Importation History</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Country of origin:</td>
<td>Date of Importation:</td>
</tr>
<tr>
<td>Is the owner also the importer?</td>
<td>Yes</td>
</tr>
<tr>
<td>If No, animal was purchased from:</td>
<td></td>
</tr>
<tr>
<td>Newspaper classified ad</td>
<td>Online classified ad</td>
</tr>
<tr>
<td>Pennysaver ad</td>
<td>Retail pet store</td>
</tr>
<tr>
<td>Breeder</td>
<td>Swap Meet</td>
</tr>
<tr>
<td>Other:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Clinical Findings</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of onset of symptoms:</td>
<td>Date of presentation:</td>
</tr>
<tr>
<td>Date of death (if applicable):</td>
<td></td>
</tr>
<tr>
<td>Summary of clinical signs:</td>
<td></td>
</tr>
<tr>
<td>Suspected condition being reported (if unknown, please state this):</td>
<td></td>
</tr>
</tbody>
</table>

| 6. Laboratory results | Please fax all relevant laboratory results along with this form. |
# Influenza Reporting Form

## 1. Animal
<table>
<thead>
<tr>
<th>Name</th>
<th>Species</th>
<th>Breed</th>
<th>Sex/Neut</th>
<th>Age</th>
</tr>
</thead>
</table>

## 2. Dog Owner

**Name(s):**  
**Street:**  
**City, ZIP:**  
**Telephone:**  

**Is it okay for Public Health to call the owner(s) to ask more about the history?**  
□ YES  □ NO

## 3. Reporting Veterinarian

**Name of veterinarian or technician:**  
**Vet Clinic Name:**  
**Address:**  
**City, ZIP:**  
**Telephone**  
**Fax**  
**E-mail:**

## 4. History

**DHLPP or FVRCP.** Date of last 2–3 vaccines if known  
**Bordetella (dogs).** Date of last 2 Bordetella vaccines.  

**Potential exposure history**
- □ Another sick animal or person in home  
- □ Dog or cat show  
- □ Kennel visit  
- □ Exposure to stray  
- □ Pet store  
- □ Shelter visit  
- □ Dog park  
- □ Other

## 5. Clinical Findings

**Date of onset of first symptoms**  
**Date of presentation**  
**Date of death (if applicable)**  
**Highest body temperature measured:**

**Check all that apply:**
- □ Cough  
- □ Nasal discharge  
- □ Sneezing  
- □ Fever  
- □ Chest X-rays taken  
- □ Patient hospitalized  
- □ IV fluids given  
- □ Supplemental oxygen given  

If nasal discharge present, please note: color, consistency, uni- or bilateral:

If chest radiographs were taken, please describe what was seen:

**Name of medications used in treatment:**

**Amount of time it took pet to recover:**  
**Date(s) serum drawn:**

**Other comments:**

## 6. Laboratory results

- Please fax all laboratory results to us along with this form.
# Leptospirosis Report Form

**Date form completed**

<table>
<thead>
<tr>
<th>1. Dog</th>
<th>Name</th>
<th>Breed</th>
<th>Sex/Neut</th>
<th>Age</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>2. Dog Owner</th>
<th>Name:</th>
<th>Address:</th>
<th>City, ZIP:</th>
<th>Telephone:</th>
</tr>
</thead>
</table>

Is it okay for Public Health to call the owner(s) to ask more about the history? □ YES □ NO

<table>
<thead>
<tr>
<th>3. Veterinarian</th>
<th>Name of veterinarian or technician:</th>
<th>Clinic Name:</th>
<th>Address:</th>
<th>City, ZIP:</th>
<th>Telephone:</th>
<th>Fax:</th>
<th>E-mail:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>4. Exposure History</th>
<th>Vaccinated against <em>Leptospira</em> before illness? □ Yes □ No</th>
<th>Date of last <em>Leptospira</em> vaccination:</th>
<th>□ bivalent □ quadrivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Travel outside of Los Angeles County? □ Yes □ No</td>
<td>Travel locations, approx dates:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Animal exposures:</td>
<td>□ Skunks □ Opossums □ Raccoons □ Deer □ Rats □ Mice □ Pigs □ Cattle □ Horses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other exposure:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Clinical Findings</th>
<th>Date of onset</th>
<th>Date of presentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of death</td>
<td>Highest body temperature measured</td>
<td></td>
</tr>
</tbody>
</table>

Clinical signs:

□ Polyuria □ Polydipsia □ Vomiting □ Diarrhea □ Icterus

□ Lethargy □ Anorexia □ Other (describe): |

<table>
<thead>
<tr>
<th>6. Treatment</th>
<th>antibiotic(s), duration:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>7. Laboratory results</th>
<th>Please send in related laboratory results (disease tests, cbc, chem etc) with form.</th>
</tr>
</thead>
</table>
Animal Methicillin-Resistant Staphylococcus Reporting Form

Please report all Methicillin-resistant Staphylococcus species, including S. aureus (MRSA), S. schleiferi (MRSS), and S. pseudointermedius (MRSP).

Date form completed __________

1. Animal □ Dog □ Cat □ Horse □ Bird □ Other _____________________________
   Name______________________Breed______________________________Sex/Neut__________Age_________

2. Animal Owner
   Name(s)
   Address
   City, ZIP
   Telephone:
   Is it okay for Public Health to call the owner(s) to ask more about the history?   YES   NO

3. Reporting Veterinarian
   Name of veterinarian or technician:
   Vet Clinic Name:
   Address:
   City, ZIP:
   Telephone       Fax       E-mail:

4. Exposure History
   Any associated human illness?   □ YES   □ NO
   Any other animals in family ill from bacteria?   □ YES   □ NO

5. Clinical Findings
   Date of onset at home___________Date of presentation___________Date of death (if applicable)_________
   Check all that apply:
   □ Fever  (highest body temperature measured ____________)
   □ Abscess          □ Skin lesions/dermatitis          □ Skin lesion/mass-like
   □ Otitis externa  □ Urinary tract infection        □ Post-operative infection
   □ Intravenous catheter   □ Surgical implant         □ Septic arthritis
   □ Other________________________Location of lesion(s) on body________________________
   Were any pictures taken of the lesion(s)?   □ Yes   □ No


7. Laboratory results. Please fax all bacterial cultures and other lab results in along with form.
## PARVO Tracking Sheet

**THANK YOU FOR HELPING US FIGHT PARVO!**

<table>
<thead>
<tr>
<th>Name</th>
<th>Breed</th>
<th>Age</th>
<th>Date seen by clinic</th>
<th>Clinical Signs</th>
<th>Vaccination Status before illness</th>
<th>Parvo Snap Test Result</th>
<th>ZIP code dog came from</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Lucky&quot; Baldwin</td>
<td>Pit X</td>
<td>5 mo</td>
<td>9/2/2010</td>
<td>□ vomiting □ anorexia □ fever □ diarrhea(brown) □ diarrhea(bloody) □ diarrhea(yellow) □ moribund</td>
<td>□ Never vax □ Unknown □ incomplete vax □ fully vax</td>
<td>□ SNAP (other) test (+)</td>
<td>95555</td>
</tr>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td>□ vomiting □ anorexia □ fever □ diarrhea(brown) □ diarrhea(bloody) □ diarrhea(yellow) □ moribund</td>
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<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>4.</td>
<td></td>
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<tr>
<td>5.</td>
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<tr>
<td>6.</td>
<td></td>
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<td>□ vomiting □ anorexia □ fever □ diarrhea(brown) □ diarrhea(bloody) □ diarrhea(yellow) □ moribund</td>
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<td>□ SNAP (other) test (+)</td>
<td></td>
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<td>7.</td>
<td></td>
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<td></td>
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<td>□ Never vax □ Unknown □ incomplete vax □ fully vax</td>
<td>□ SNAP (other) test (+)</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td></td>
<td></td>
<td></td>
<td>□ vomiting □ anorexia □ fever □ diarrhea(brown) □ diarrhea(bloody) □ diarrhea(yellow) □ moribund</td>
<td>□ Never vax □ Unknown □ incomplete vax □ fully vax</td>
<td>□ SNAP (other) test (+)</td>
<td></td>
</tr>
</tbody>
</table>

### Veterinary Clinic Information

- **Clinic name:**
- **Tel #:**

**Fax to:** 213-481-2375

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2.15.11 EB

*County of Los Angeles Public Health*

Veterinary Public Health & Rabies Control
Tel. 213-989-7060
# Psittacosis Reporting Form

**Date form completed** __________

## 1. Bird
- Name_________________
- Species_________________
- Sex(if known) _______
- Age_________

## 2. Bird Owner
- Name(s)_________________
- Address_________________
- City, ZIP_________________
- Telephone: ______________

*Los Angeles County Public Health will contact the owner about the standard 45-day quarantine period.*

## 3. Reporting Veterinarian
- Name of veterinarian or technician: ________________
- Vet Clinic Name: ________________
- Address: ________________
- City, ZIP: ________________
- Telephone: ________________
- Fax: ________________
- E-mail: ________________

## 4. History
- a. How long has this person owned this bird? __________
- Date bird obtained (if known) ______________________
- c. Store/Individual selling bird to owner (if within last 60 days) __________________________________________
- d. Are there other birds on owner’s property? □ No □ Yes
  - If yes, how many? __________
  - Is there any known illness in these other birds? □ No □ Yes
- e. Were any new birds brought onto property recently? □ No □ Yes
  - If yes, explain __________________________________________
- f. Type of housing of infected bird: □ Indoor □ Outdoor
- g. Is there any known human respiratory illness in people that handle the infected bird? □ No □ Yes
  - If Yes, please explain______________________________________

## 5. Clinical Findings
- a. Date of onset of first symptoms ________________
- b. Date of presentation ________________
- c. Date of death (if applicable) ________________
- d. Check all that apply
  - □ No clinical signs
  - □ Lethargy
  - □ Anorexia
  - □ Diarrhea
  - □ Respiratory signs
  - □ Sudden death
  - □ Other ________________________________
  - □ Other (explain): ________________________________

## 6. Diagnostics/Laboratory results
*Please fax all laboratory results to us along with this form.*

Fax to: (213) 481-2375

5/2013
Tick-borne Disease Reporting Form

Date form completed __________

1. Disease □ Anaplasmosis □ Ehrlichiosis
□ Borreliosis (Lyme) □ Spotted Fever Rickettsiosis (Rocky Mountain Spotted Fever)

2. Pet □ Dog □ Cat □ Other __________________________
Name_________________________ Breed_______________________ Sex/Neut__________ Age_________

3. Pet Owner
Name(s) ________________________
Address ________________________
City, ZIP _______________________
Telephone: _____________________ May we call the owner(s) to ask more about the history? □ YES □ NO

4. Reporting Facility
Veterinarian or technician: ___________________________________________________________
Clinic or Shelter Name: _____________________________________________________________
Address: ________________________
City, ZIP: _______________________
Telephone: _____________________ Fax: _________________________ E-mail: __________________

5. Tick Exposure History
Ticks from pet saved in alcohol for identification? □ Yes □ No
Owner reports seeing ticks on pet earlier? □ Yes □ No
Parks and places in LA County the pet visits: _____________________________________________

Does the pet visit places outside of LA County? □ Yes □ No
Where? __________________________________________________________________________

6. Clinical Findings
Date of onset ________________ Date of presentation __________________ Date of death __________
Highest body temperature measured ______________
Check all that apply:
□ Fever □ Anorexia □ Vomiting
□ Epistaxis □ Petechiae/ecchymoses □ Enlarged lymph node(s)
□ Neurosigns □ Edema □ Lameness
Please describe: ___________________________________________________________________

7. Treatments: (Ex. antibiotics or corticosteroids, ectoparasite control)

8. Laboratory results. Please fax all laboratory results along with this form.
Vaccine Preventable Disease Reporting Form

**Date form completed**

**SUSPECTED DISEASE BEING REPORTED:**
- □ Parvovirus
- □ Canine distemper
- □ Panleukopenia
- □ Other_____________________

**1. Pet** □ Dog □ Cat

<table>
<thead>
<tr>
<th>Name</th>
<th>Breed</th>
<th>Sex/Neut</th>
<th>Age</th>
</tr>
</thead>
</table>

**2. Pet Owner**

<table>
<thead>
<tr>
<th>Name(s)</th>
<th>Address</th>
<th>City, ZIP</th>
<th>Telephone</th>
</tr>
</thead>
</table>

Is it okay for Public Health to call the owner(s) to ask more about the history?  YES  NO

**3. Reporting Veterinarian**

<table>
<thead>
<tr>
<th>Name of veterinarian or technician:</th>
<th>Vet Clinic Name:</th>
<th>Address:</th>
<th>City, ZIP:</th>
<th>Telephone</th>
<th>Fax</th>
<th>E-mail:</th>
</tr>
</thead>
</table>

**4. History**

Relevant vaccine history, include dates of vaccine:

Is this case part of a cluster or outbreak? If yes, please explain:
- Potential exposure history
  - □ Another sick animal in home
  - □ Dog show
  - □ Kennel visit
  - □ Exposure to stray
  - □ Pet store
  - □ Shelter visit
  - □ Dog park
  - □ Other ____________________________

**5. Clinical Findings**

Date of onset of first symptoms__________ Date of presentation______________

Date of death (if applicable)______________ Highest body temperature measured: ______________

Check all that apply:
- □ Cough
- □ Nasal Discharge
- □ Vomit
- □ Diarrhea
- □ Tremors
- □ Seizures
- □ Other neurological signs
- □ Parvo snap test in-house - positive
- □ Positive distemper titer with no prior vaccination
- □ Positive distemper antigen IFA

Other (explain):

**6. Laboratory results.** Please fax all laboratory results to us along with this form.