



DEPARTMENT OF AGRICULTURE

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FAX: 860-713-2505

Disease: _____

Date: _____

REPORTABLE DISEASE RECORD

Reported by: Veterinarian Owner Other: _____

Veterinarian:

Name: _____

Address: _____

Phone: _____

FAX: _____

Hours: _____

Owner:

Name: _____

Address: _____

Phone: _____

FAX: _____

Hours: _____

Animal or **Bird**

Species: _____

Breed: _____

Description: _____

Name and/or ID: _____

Age or Birth Date: _____

Sex: Male Female Unknown

Vaccinations: _____

No. in Group: _____

Type of Housing: _____

Address Where Housed: _____

Travel History: Yes No
When? _____

Where? _____

Veterinarian:

Date of 1st visit: _____

Clinical Signs on Presentation:

Treatment: _____

Owner:

Date of Onset: _____

Clinical Signs or Major Complaint:

Outcome: Survived _____ Died (date): _____ Euthanized (date): _____ Necropsy (date): _____

Date Samples Collected: _____ Type of Samples: Blood Serum CSF Brain Other: _____

Tests Requested: _____ Lab Used: _____

Results: _____

Attach Copies of Lab Results, Necropsy Report and other documents to record.

Contacts: Veterinarian Owner State DPH Local Health Other: _____

Date: _____