

# VETERINARY HARMFUL ALGAL BLOOM (HAB) CASE REPORT FORM

Please include any relevant medical records or test results with this report. Additionally, please inform the animal's owner that we might contact them for more information about their animal's exposure.

DEMOGRAPHIC INFORMATION	ILLNESS HISTORY	EXPOSURE	LABORATORY INFORMATION	OUTCOME & TREATMENT
<b>Owner name:</b> _____				
<b>Address:</b> _____ <b>County:</b> _____				
<b>City:</b> _____ <b>State:</b> _____ <b>Zip:</b> _____				
<b>Phone (1):</b> _____ <b>Phone (2):</b> _____				
<b>Animal name or ID:</b> _____ <b>Species:</b> _____				
<b>Breed:</b> _____ <b>Age:</b> _____ <b>Weight (lbs):</b> _____ <b>Gender:</b> <input type="checkbox"/> M <input type="checkbox"/> F				
<b>Reporter:</b> _____ <b>Reporting date:</b> ____/____/____				
<b>Hospital/Clinic:</b> _____ <b>Clinic phone:</b> _____				
<b>Onset date:</b> ____/____/____ <b>Recovery date:</b> ____/____/____ <b>Presentation:</b> _____				
<input type="checkbox"/> Dark urine <input type="checkbox"/> Jaundice <input type="checkbox"/> Fever max temp: _____ °F				
<input type="checkbox"/> Anorexia <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea # of stools/24hrs: _____				
<input type="checkbox"/> Pale mucous membranes <input type="checkbox"/> Cough <input type="checkbox"/> Rash Location: _____				
<input type="checkbox"/> Rapid breathing <input type="checkbox"/> Drooling <input type="checkbox"/> Lameness Describe: _____				
<input type="checkbox"/> Lethargy <input type="checkbox"/> Shock <input type="checkbox"/> Paralysis/Paresis Describe: _____				
<input type="checkbox"/> Seizure <input type="checkbox"/> Other: _____				
<b>Name of waterbody:</b> _____				
<b>Location on waterbody:</b> _____ <b>Closest city:</b> _____				
<b>Last date of exposure:</b> ____/____/____ <b>Time:</b> _____ to _____				
<b>Lab name:</b> _____				
<b>Was a complete blood count test performed?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Collection date:</b> ____/____/____				
<b>Results:</b> _____				
<b>Was a serum chemistry panel performed?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Collection date:</b> ____/____/____				
<b>Results:</b> _____				
<b>Was a toxin identification test performed?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Collection date:</b> ____/____/____				
<b>Toxin identified:</b> _____ <b>Specimen type:</b> _____				
<b>Lab test(s) performed:</b> _____				
<b>Lab name (if different from above):</b> _____				
<b>Describe any treatment that was given:</b> _____				
<b>Was the animal hospitalized?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Admit date:</b> ____/____/____ <b>Discharge date:</b> ____/____/____				
<b>Did the animal die?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, date:</b> ____/____/____				
<b>Did the animal die as a result of HAB illness?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Was the animal euthanized?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>Was a necropsy performed?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, date:</b> ____/____/____				
<b>Describe the findings:</b> _____				