



REPORTABLE DISEASE FORM

Disease:		Date:	
Name of Owner:		Address of Owner:	
City:		State:	Zip:
Animal ID:		Age:	
Breed:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Address of Animal's location:		Parish Where Animal Resides:	
City:		State:	Zip:
Vaccination Status	<input type="checkbox"/> Previously vaccinated? If so, when? <input type="checkbox"/> Not up to date? <input type="checkbox"/> Never vaccinated?		
Did it live?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Was it euthanized?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Did it die? (not euthanized)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Blood or samples taken?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sent to:
Other Pertinent Data or Comments:			
Veterinarian:		E-Mail:	
Phone:		Fax:	

Return by FAX to: (225) 237-5555

Return by E-Mail to: vetreports@ldaf.state.la.us

Call: (225) 925-3980

Remember to send this form in upon "Suspicion of disease". We especially need the parish where the animal resides.