



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.