



VETERINARY PUBLIC HEALTH-RABIES CONTROL PROGRAM

Tel. (213) 989-7060 or 877-747-2243 Fax (213) 481-2375

publichealth.lacounty.gov/vet



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
Type of animal involved: [] Domestic Pet [] Livestock [] Wild animal
[] Exotic [] Zoo animal
Number of animals: [] One [] Multiple (give number _____)
Species of Animal _____
Other Identifying Information:
Breed _____ Color _____
Sex _____ Name _____
Age _____ IMPOUND # _____

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

2. Animal Location (where in community originally found, if not same as owner)
Name(s)
Address
City, ZIP

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

4. History
Date of onset of first symptoms _____ Date of presentation _____
Date of death(s), if applicable _____
History (include vaccine history, if applicable):

5. Clinical Findings

Highest body temperature measured _____

Physical Examination

	Normal	Comments
General:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Skin:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Head Area:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Respiratory:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Cardiovascular:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Abdomen/digestive:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Urogenital:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Musculoskeletal:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Nervous:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Lymph nodes:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

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

Treatment Date	Describe Treatment
1. _____	_____
2. _____	_____
3. _____	_____

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

8. Additional comments. Please use an additional sheet if needed.



Canine Brucellosis Reporting Form

Date form completed _____

1. Dog

Name _____ Breed _____ Sex/Neut _____ Age _____

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
If YES, how many other dogs are in the home? _____
- 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:

- | | | | |
|--------------------------------------------------|----------------------------------------------------------------------|-------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> no clinical signs | <input type="checkbox"/> fever | <input type="checkbox"/> lethargy | <input type="checkbox"/> exercise intolerance |
| <input type="checkbox"/> urinary tract infection | <input type="checkbox"/> abortion | <input type="checkbox"/> diskospondylitis | <input type="checkbox"/> epididymitis |
| <input type="checkbox"/> ocular lesions | <input type="checkbox"/> enlarged lymph nodes. Node locations: _____ | | |
| <input type="checkbox"/> other _____ | | | |

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



Canine Influenza Reporting Form

Date form completed _____

1. Dog Name _____ Breed _____ Sex/Neut _____ Age _____

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. Date of last 2 – 3 DHPP or DHLPP vaccines if known _____

Bordetella. Date of last 2 Bordetella vaccines. _____ Intranasal Injectable

_____ Intranasal Injectable

Potential exposure history

Another sick dog 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

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 dog to recover: _____

Date(s) serum drawn _____

Other comments _____

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



Coccidioidomycosis Reporting Form

Date form completed _____

1. Pet Dog Cat Other
 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

(fill in as known)

Dog lives primarily outdoors (more than 50% of time). Yes No

Dog likes to dig in soil frequently. Yes No

Dog/family live within site of earth excavation. Yes No

Dog/family live on a dirt road Yes No

Dog has been in dust storm within 2 months before illness. Yes No

Dog has been to the following locations within 2 months before illness:

- | | | |
|---------------------------------------------|------------------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Mojave Desert Area | <input type="checkbox"/> Central Valley/San Joaquin Valley | <input type="checkbox"/> Arizona |
| <input type="checkbox"/> New Mexico | <input type="checkbox"/> Southern Nevada | <input type="checkbox"/> Southwestern Texas |
| <input type="checkbox"/> Southern Utah | <input type="checkbox"/> Northern Mexico | <input type="checkbox"/> Central or 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:

- | | |
|--------------------------------------------------------------------------|------------------------------------------------------------------------|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Lameness |
| <input type="checkbox"/> Enlarged lymph node(s) (node location(s) _____) | |
| <input type="checkbox"/> Eye lesions | <input type="checkbox"/> Pneumonia/Pulmonary lesion seen on radiograph |
| <input type="checkbox"/> Bone lesion seen on radiograph | <input type="checkbox"/> Other: _____ |

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



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Heartworm Reporting 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 LA County Yes No

If yes, please note location and date: _____

Other exposure _____

5. Clinical Findings

Date of onset of first symptoms _____ Date of presentation _____

Date of death (if applicable) _____

Clinical Signs (check all that apply)

None Cough Fatigue Heart failure

Other _____

Thoracic radiographs taken? Yes No

If yes, please note date and comment on findings _____

6. Heartworm Tests and Treatment

Heartworm blood test date	Test type (Ag, Ab, microfilaria)	Test Result
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Treatment Date	Describe Treatment
1. _____	_____
2. _____	_____
3. _____	_____

Fax to: (213) 481-2375

Rev 4/2010 EB



2010



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.



Leptospirosis Reporting Form

Date form completed _____

1. Dog Name _____ Breed _____ Sex/Neut _____ Age _____

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. History

Vaccination

Date of last leptospirosis vaccine (if known): _____

Vaccine type (ex. DHLPP or 4-way Lepto vaccine): _____

Potential exposure history

Exposure/travel outside of Los Angeles County? Yes No

If yes, please note location and date: _____

Dog has/had local exposure to (check all that apply):

- Skunks Opossums Raccoons Deer Rats
 Mice Pigs Cattle Horses

Other potential exposure: _____

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:

- Anorexia Lethargy Vomiting Diarrhea
 Visible jaundice/icterus Polyuria Polydipsia
 Other (describe): _____

Were intravenous fluids given? Yes No

6. Laboratory results

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



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	<input type="checkbox"/> Dog	<input type="checkbox"/> Cat	<input type="checkbox"/> Horse	<input type="checkbox"/> Bird	<input type="checkbox"/> 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?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Any other animals in family ill from bacteria?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

5. Clinical Findings		
Date of onset at home _____	Date of presentation _____	Date of death (if applicable) _____
<u>Check all that apply:</u>		
<input type="checkbox"/> Fever (highest body temperature measured _____)	<input type="checkbox"/> Skin lesions/dermatitis	<input type="checkbox"/> Skin lesion/mass-like
<input type="checkbox"/> Abscess	<input type="checkbox"/> Urinary tract infection	<input type="checkbox"/> Post-operative infection
<input type="checkbox"/> Otitis externa	<input type="checkbox"/> Surgical implant	<input type="checkbox"/> Septic arthritis
<input type="checkbox"/> Intravenous catheter	<input type="checkbox"/> Other _____ Location of lesion(s) on body _____	
Were any pictures taken of the lesion(s)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

6. Treatment. Please comment on antibiotics administered and response to treatment.

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



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Avian 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

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Canine Rocky Mountain Spotted Fever Reporting Form

Date form completed _____

1. Dog Name _____ Breed _____ Sex/Neut _____ Age _____

2. Dog Owner

Name(s)

Address

City, ZIP

Telephone:

May we 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. Tick Exposure History

Type of neighborhood dog lives in: Urban Suburban Rural

Ticks found on dog within 7 days before illness: Yes No

Ticks found on dog within past 3 months: Yes No

Is the dog walked outside of its own neighborhood: Yes No

Locations of trails/parks/other places in LA County the dog visits:

Does the dog visit places outside of LA County? Yes No

List locations outside of LA County the dog might have been exposed to ticks:

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:

Fever Anorexia Petechiae/ecchymoses Vomiting Diarrhea

Cough Enlarged peripheral lymph nodes Conjunctivitis/scleral injection

Seizures/vestibular disease/neuro Edema (body location _____)

Polyarthritis (joints involved _____)

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

7. 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

Name _____ Breed _____ Sex/Neut _____ Age _____

2. Pet 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. 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.

Fax to: (213) 481-2375

2010