HAIR ROOTS AND BLOOD
SAMPLE SUBMISSION FORM: Case/Affected Horse
SHIP TO: Dr. Molly McCue, c/o Kendall Blanchard
225 Veterinary Medical Center
1365 Gortner Ave
St. Paul, Minnesota 55108

ID NUMBER (LABORATORY USE ONLY):

A. OWNER INFORMATION

FIRST/LAST NAME: _____
STREET ADDRESS/PO BOX: _____
_____
CITY: _____ STATE: _____ ZIP/POSTAL CODE: _____
COUNTRY: _____

TEL. PHONE:

E-MAIL:

B. HORSE INFORMATION

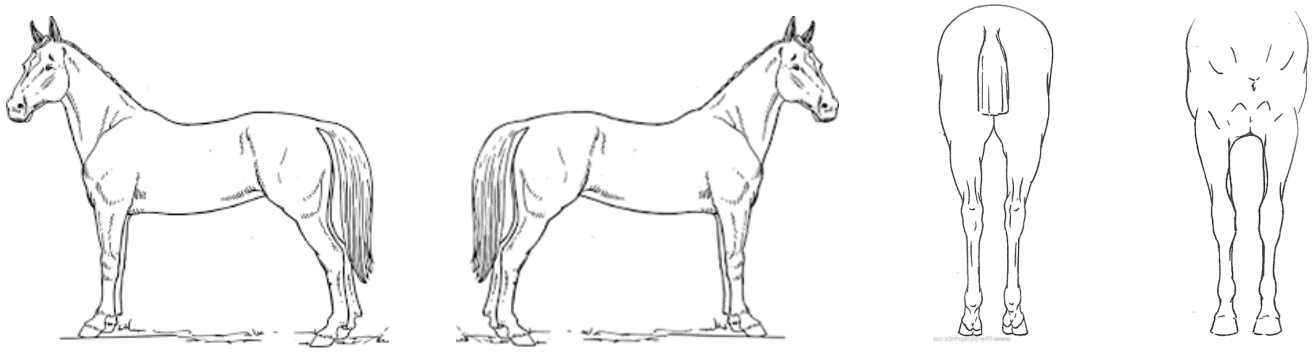
BARN/CALL NAME: _____
BREED: _____
GENDER:
□ MALE INTACT (STALLION/COLT) / □ MALE CASTRATED (GELDING)
□ FEMALE INTACT (MARE/FILLY) / □ FEMALE PREGNANT (PREGNANT MARE) / □ FEMALE SPAYED (SPAYED MARE)

SAMPLE TYPE:

□ HAIR ROOTS

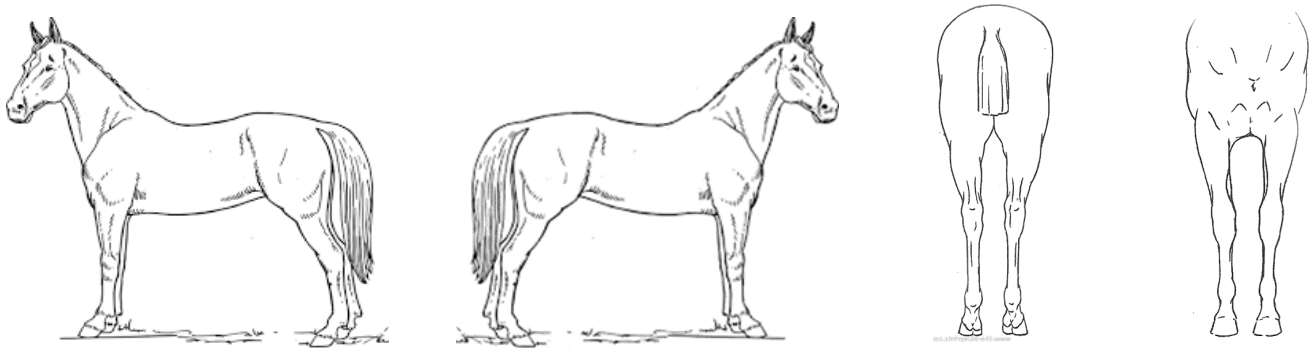
□ BLOOD

IF APPLICABLE, PLEASE WRITE AN "**X**" ON THE AREAS IN WHICH YOUR AFFECTED HORSE EXPERIENCES **MUSCLE FASCICULATIONS:**



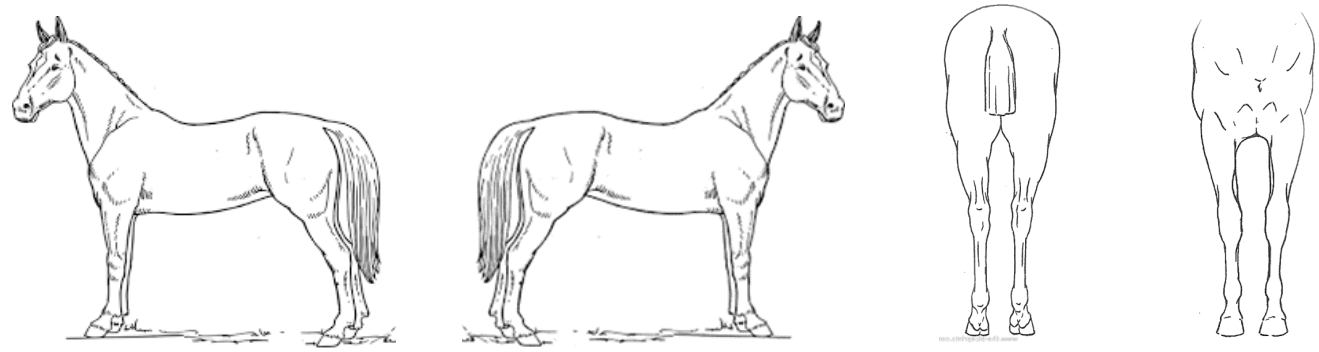
LEFT **RIGHT** **BACK** **FRONT**

IF APPLICABLE, PLEASE WRITE AN "**X**" ON THE AREAS IN WHICH YOUR AFFECTED HORSE EXPERIENCES **MUSCLE ATROPHY**:



LEFT **RIGHT** **BACK** **FRONT**

IF APPLICABLE, PLEASE WRITE AN "**X**" ON THE AREAS IN WHICH YOUR AFFECTED HORSE EXPERIENCES **LAMENESS**:



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