STATE

ALL INCOMPLETE RECORDS WILL BE RETURNED FOR COMPLETION

COOPERATIVE STATE - FEDERAL SCRAPIE CONTROL PROGRAM

SCRAPIE TEST RECORD

FORM APPROVEDOMB NO. 0579-0101

A

REFERRAL NO.

COUNTY OF OWNER	FLOCK OWNER'S NAME - LAST	FIRST	MI	PREVIOUS TEST DATE	PERSON ID (VETERINARIAN/SNGD)	TOTAL # OF SAMPLES

FLOCK ID

FLOCK OWNER'S COMPLETE ADDRESS

CERTIFICATION FOR PAYMENT

☐ Cooperative Agreement ☐ State/Federal Expense ☐ Owner's Expense

I certify:
That this test was made by me on the animals identified below on the dates as entered in appropriate spaces.
That when payment is claimed at program expense in accordance with agreement number below, no payment has been or will be received from any other source.

COUNTY OF FLOCK	FLOCK OWNER'S TELEPHONE NUMBER	SEC.	FARM NO.

REASON FOR TEST

1 SURVEILLANCE		6 RETEST	
2 FLOCK (RE) CERTIFI-CATION		7 INFECTED OR SOURCE RSSS POS.	
3 HIGH RISK TRACE TO FLOCK		8 INFECTED OR SOURCE (NOT RSSS)	
4 OWNER'S REQUEST		9 MISSING EXPOSED EWE (ME)	
5 IMPORTED		10 OTHER	

COMPLETE FLOCK TEST OF ALL ELIGIBLE ANIMALS: ☐ YES ☐ NO

NO. OF ANIMALS IN FLOCK _____

KIND OF FLOCK

☐ SHEEP ☐ GOAT ☐ MIXED ☐ OTHER _____

LAB TURN AROUND TIME

☐ 5 DAY TURNAROUND ☐ 10 DAY TURNAROUND

TEST TYPE

☐ 171 CODON ONLY ☐ 171/136 CODON
☐ 136 CODON ONLY ☐ 171/136/154 CODON
☐ THIRD EYELID *(TE)* ☐ OTHER _____

VETERINARIAN'S SIGNATURE | **TELEPHONE NO**

VETERINARIAN'S NAME *(Please print)* | **COLLECTION DATE**

VETERINARIAN'S ADDRESS

FAX NO. OR E-MAIL ADDRESS | **AGREEMENT NO.**

FLOCK STATUS

☐ SFCP ☐ EXPOSED ☐ INFECTED
☐ NONE ☐ SOURCE ☐ INVEST
☐ OTHER _____

Specimen #	Official ID Number	Other ID Numbers	Designation (pos, sus, exp, me, n/a)	Age	Sex (m,f,cm)	Breed (if unkn, face color)	3rd Eyelid Info		
							L	R	Seen Unseen
							L	R	Seen Unseen
							L	R	Seen Unseen
							L	R	Seen Unseen
							L	R	Seen Unseen
							L	R	Seen Unseen
							L	R	Seen Unseen
							L	R	Seen Unseen
							L	R	Seen Unseen
							L	R	Seen Unseen

NOTE: Sample numbers on specimens must be the same as listed on this form.

☐ ☐
Circle if the 3rd eyelid tissue came from the Left or Right eye
Circle if the lymphoid tissue was Seen or Unseen

DSE Name:

Address:

Phone Number:

Fax Number:

E-Mail:

Remarks:

DATE

OWNER'S SIGNATURE:

I hereby acknowledge receiving a copy of this record which I have examined and find correct.

VS FORM 5-29
(SEP 2007)

USE TYPEWRITER OR PRINT CLEARLY - PRESS HARD - YOU ARE MAKING 5 COPIES

COPY DESIGNATION

RED INK - CENTER OF BOTTOM OF PAGE

PART 1 - Area Office

PART 2 - Laboratory

PART 3 - DSE

PART 4 - VMO

PART 5 - Owner