



VETERINARY LARGE ANIMAL HARMFUL ALGAL BLOOM (HAB) CASE REPORT FORM

Revised 6/2014

DEMOGRAPHIC INFORMATION

Owner Name:	Age:	Weight (lbs):
Animal Name or ID:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	
Species: Breed:	Animal is primarily in: <input type="checkbox"/> Confinement <input type="checkbox"/> Pasture <input type="checkbox"/> Both	
Address:	Veterinarian:	
City: Zip:	Clinic Name:	
Phone (1): (2):	Clinic Phone:	

ILLNESS HISTORY

Onset date: ___/___/___	Recovery date: ___/___/___	Presentation: <input type="checkbox"/> BAR <input type="checkbox"/> Recumbent <input type="checkbox"/> Comatose <input type="checkbox"/> Deceased	
Fever <input type="checkbox"/> Y <input type="checkbox"/> N max temp: _____°F	Diarrhea <input type="checkbox"/> Y <input type="checkbox"/> N # of stools/24hrs: _____	Drooling <input type="checkbox"/> Y <input type="checkbox"/> N	Lameness <input type="checkbox"/> Y <input type="checkbox"/> N
Lethargy <input type="checkbox"/> Y <input type="checkbox"/> N	Vomiting <input type="checkbox"/> Y <input type="checkbox"/> N	Rapid breathing <input type="checkbox"/> Y <input type="checkbox"/> N	Describe: _____
Off feed <input type="checkbox"/> Y <input type="checkbox"/> N	Rash <input type="checkbox"/> Y <input type="checkbox"/> N	Dark urine <input type="checkbox"/> Y <input type="checkbox"/> N	Paralysis/Paresis <input type="checkbox"/> Y <input type="checkbox"/> N
Cough <input type="checkbox"/> Y <input type="checkbox"/> N	Location: _____	Jaundice <input type="checkbox"/> Y <input type="checkbox"/> N	Describe: _____
Other: _____		Pale mucous membranes <input type="checkbox"/> Y <input type="checkbox"/> N	Seizure <input type="checkbox"/> Y <input type="checkbox"/> N
			Shock <input type="checkbox"/> Y <input type="checkbox"/> N

EXPOSURE INFORMATION

Date of exposure: ___/___/___	Time: _____ to _____	Visible algae or scum present? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK
Name of waterbody: _____		Water color: _____
Location on waterbody: _____		Unusual smells? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK Describe: _____
City: _____		Water flow: <input type="checkbox"/> Moving <input type="checkbox"/> Stagnant <input type="checkbox"/> DK

LABORATORY INFORMATION

Lab name: _____

Complete blood count (most abnormal): Collection date: ___/___/___

WBC: _____ NEU: _____ LYM: _____ RBC: _____ HGB: _____ HCT: _____ PLT: _____

Abnormal morphology seen on blood smear: _____

Serum chemistry panel (most abnormal): Collection date: ___/___/___

Alb: _____ ALP: _____ AST: _____ TBili: _____ CK: _____

TP: _____ GGT: _____ SDH: _____ Gluc: _____

Was a cyanotoxin identified in a sample? No: Yes: Animal Water If yes, toxin identified: _____

List the laboratory test(s) and specimen type(s) used to identify the toxin: _____

Specimen collection date: ___/___/___ Lab name (if different from above): _____

OUTCOME & TREATMENT

Was the animal hospitalized? <input type="checkbox"/> Y <input type="checkbox"/> N Admin date: ___/___/___ Discharge date: ___/___/___	Describe the treatment that was given: _____
Did the animal die? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, date: ___/___/___	_____
Did the animal die as a result of HAB illness? <input type="checkbox"/> Y <input type="checkbox"/> N If no, cause of death: _____	Was a necropsy performed? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, date: ___/___/___
Euthanized? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, date: ___/___/___	Describe findings: _____
Reason: <input type="checkbox"/> Poor prognosis <input type="checkbox"/> Expense of treatment	_____
<input type="checkbox"/> Both <input type="checkbox"/> Other: _____	_____

Please fax completed form to the MDH Waterborne Diseases Unit at: 1-800- 233-1817