



## Veterinarian's Reportable Disease Form

Veterinary practitioners are the first line of defense in detecting reportable animal diseases. We appreciate your efforts to protect animal and public health in Washington State.

Please use dropdown lists (marked with \*) and fill in all **required** and applicable fields. Once you have completed the form, please save a copy for your records and email a copy, along with any available laboratory results, to [WSDADiseaseReporting@agr.wa.gov](mailto:WSDADiseaseReporting@agr.wa.gov). See [WAC 16-70](#) for information on animal disease reporting requirements in Washington State. If you have questions, please call (360) 902-1878 or email [WSDADiseaseReporting@agr.wa.gov](mailto:WSDADiseaseReporting@agr.wa.gov).

Today's Date (MM/DD/YYYY)

| Veterinarian Information   |  |  |   |
|--|--|--|---|
| Veterinarian Name  |  | Clinic Name  |   |
| Address  |  | City   | State *   |
|  |  | Zip Code   |   |
| Veterinarian Phone   |  | Veterinarian Email   |   |
| Patient Information  |  |  |   |
| Owner Name   | Owner Phone  | # of Affected Animals (report individual cases when possible)  |   |
| Species *  | Species (if other)   | Breed  | Patient Status (select one)<br><input type="checkbox"/> Alive <input type="checkbox"/> Dead <input type="checkbox"/> Euthanized |
| Patient Name   | Patient Age<br><input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years | Patient Sex & Alteration History<br><input type="checkbox"/> Female <input type="checkbox"/> Male & <input type="checkbox"/> Altered <input type="checkbox"/> Intact |   |
| Patient Purpose<br><input type="checkbox"/> Domestic <input type="checkbox"/> Production <input type="checkbox"/> Other:   |  | Patient County of Residence *  |   |
| Has the patient ever traveled outside of WA State?<br><input type="checkbox"/> Yes (complete Patient Origin & Patient Travel History) <input type="checkbox"/> No <input type="checkbox"/> Unknown |  | Patient Origin (last known location before WA State)   |   |
| Patient Travel History   |  |  |   |
| Case Information   |  |  |   |
| Reportable Disease *   |  | Disease (if other)   |   |
| Date of Illness Onset (MM/DD/YYYY)   |  | Case Status<br><input type="checkbox"/> Clinical <input type="checkbox"/> Lab Confirmed <input type="checkbox"/> Lab Requested                                       |   |
| Laboratory Name (if confirmed/requested)   |  | Test Type (if confirmed/requested)   |   |
| Please send lab results (if available) with this form immediately to: <a href="mailto:WSDADiseaseReporting@agr.wa.gov">WSDADiseaseReporting@agr.wa.gov</a>   |  |  |   |
| Notes  |  |  |   |
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