UC DAVIS VETERINARY MEDICINE
Veterinary Medical Teaching Hospital

Sample Submission Form
SarcoFluor™, NeoFluor™, ToxoFluor™ Testing (EPM & Toxo)

SarcoFluor™, NeoFluor™, and ToxoFluor™ sample requirements: Serum in a red top tube and/or a clean cerebrospinal fluid (CSF) tap.

CSF fluid analysis sample requirements: CSF in a red top tube (no anticoagulant).

Sample processing: Spin blood and **separate serum to a new, clean, tube**. Serum separator tubes are not recommended. DO NOT spin CSF. A handling fee will be assessed for unprocessed or improperly processed blood samples

Shipping: Ship on a cold pack for overnight delivery, Monday-Thursday only, to the address below.
UC Davis VMTH, Central Laboratory Receiving, Room 1033, 1 Garrod Drive, Davis, CA 95616
530-752-VMTH (8684), fax 530-752-5055

For more information, visit our website: www.vetmed.ucdavis.edu/clinical-laboratory

Tests Requested

Check the test(s) requested. If no selections are made, an IFAT panel (SarcoFluor™ & NeoFluor™) will be run
Ratio results are available only if serum AND CSF are submitted simultaneously; CSF fluid analysis is recommended.

☐ **IFAT Panel:** SarcoFluor™ & NeoFluor™
☐ **ToxoFluor™**
☐ **CSF Fluid Analysis** (recommended with CSF submissions)

☐ **STAT:** results in 3 days. Additional fee.

☐ SarcoFluor™ only
☐ NeoFluor™ only

samples submitted with this form: ___ serum ___CSF

Serum collection date	CSF collection date and site

Patient Information

Name	Breed
Sex	Age/DOB
Use	

Owner Information

Name	Address

Submitting Veterinarian Information

Clinic name	Clinic Address
Veterinarian name	
Phone	VMTH Client ID
Fax	Email
Preferred method of results reporting. Choose one only; if no choice is made, results are faxed	☐ Fax ☐ Email

Clinical History

(1) Check any or all clinical signs observed

☐ Muscle atrophy ☐ Lameness ☐ Hind limb ataxia (grade ___) ☐ Behavior change
☐ Facial paralysis ☐ Seizures ☐ Fore limb ataxia (grade ___) ☐ Hypermetria
☐ Head tilt ☐ Circling ☐ Central blindness ☐ Weakness
☐ Tongue atrophy ☐ Other (describe)

(2) Duration of clinical signs? _____ days/weeks/month/years

(3) Has horse been treated for EPM? ☐ No ☐ unknown ☐ Yes (duration & date) _____

(4) Vaccinated against rabies? ☐ No ☐ unknown ☐ Yes (date) _____
West Nile? ☐ No ☐ unknown ☐ Yes (date) _____

(5) Have cervical radiographs or myelogram been done? ☐ No ☐ Yes (if so, attach report or finding)

(6) Additional information:

