

<b>USDA BSE Surveillance Data Collection Form</b>	<b>Collection Date:</b>	<b>BSE Referral Number</b>
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**PRIMARY REASON FOR SUBMISSION** (Check the selection with the smallest number that applies (e.g., if both #1 and #4 are applicable, select #1))

<input type="checkbox"/> 1. Highly suspicious for BSE	<input type="checkbox"/> 5. Nonambulatory / Disabled / Downer
<input type="checkbox"/> 2. FSIS, antemortem condemned cattle	<input type="checkbox"/> 6. Other clinical signs possibly associated with BSE as noted below
<input type="checkbox"/> 3. Rabies suspect	<input type="checkbox"/> 7. Dead
<input type="checkbox"/> 4. CNS signs	

1

**BSE Sample ID:**

Please Use Barcode if Available

**Individual who determined primary reason noted above and clinical signs listed below (Select one)**

<input type="checkbox"/> 1. Veterinarian employed by APHIS	<input type="checkbox"/> 5. Renderer / deadstock hauler / 3D-4D
<input type="checkbox"/> 2. Veterinarian employed by FSIS	<input type="checkbox"/> 6. Producer / owner
<input type="checkbox"/> 3. Other Veterinarian	<input type="checkbox"/> 7. Other (Describe in below)
<input type="checkbox"/> 4. Other APHIS personnel	

Owner Information	SLAUGHTER SITE or <input checked="" type="checkbox"/> if Same as Collection Site <small>(Complete only if slaughtered at state – or FSIS – inspected facility)</small>
Business Name:	Premises ID: _____ or FSIS Plant # _____
Name:	Business Name:
Street:	Name:
City: _____ State: _____ Zip: _____	Street:
Country (If not USA): _____ Lat / Long: _____	City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____	Phone: _____ Fax: _____
County: _____ E-mail: _____	E-mail: _____

<b>Breed (If known)</b> _____ <b>If not known – Please check one</b> <input type="checkbox"/> Beef breed <input type="checkbox"/> Dairy breed <b>Primary colors:</b> _____	<b>Age:</b> _____ <input type="checkbox"/> Months <input type="checkbox"/> Years  <b>Age is:</b> <input type="checkbox"/> Estimated <input type="checkbox"/> Recorded  <b>Dentition: 2<sup>nd</sup> Set of Incisors Erupted:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Gender:</b> <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Unknown  <b>Neutered:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>Country of Origin</b> (Only if KNOWN to be other than USA)
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Official USDA Tag #	Official USDA Tag #	FSIS Condemnation Tag # Z -	Owner Ear Tag #	Other ID Type #
Collection Site Tracking #	Slaughter Tracking #	Back Tag #	Microchip #	Other ID Type #

**Clinical Signs (Select all that apply. Be thorough and complete. Clinical signs are important for determination of the significance of each sample to the surveillance program. Obtain information directly from animal handlers/owner whenever possible.)**

<table style="width:100%;"> <tr> <td><input type="checkbox"/> Abnormal head carriage</td> <td><input type="checkbox"/> Head pressing / rubbing</td> </tr> <tr> <td><input type="checkbox"/> Aggressive or belligerent</td> <td><input type="checkbox"/> Head shyness</td> </tr> <tr> <td><input type="checkbox"/> Apprehension or nervous</td> <td><input type="checkbox"/> Hyperesthesia <small>(includes sensitivity to light, sudden movements to loud sounds, shifting ears)</small></td> </tr> <tr> <td><input type="checkbox"/> Ataxia <small>(abnormal gait, uncoordinated)</small></td> <td><input type="checkbox"/> Hesitation at doors, gates, or barriers</td> </tr> <tr> <td><input type="checkbox"/> Blindness</td> <td><input type="checkbox"/> Kicking during milking <small>(when did not before)</small></td> </tr> <tr> <td><input type="checkbox"/> Circling</td> <td><input type="checkbox"/> Paralysis</td> </tr> <tr> <td><input type="checkbox"/> Droopy lip or eyelid</td> <td><input type="checkbox"/> Tremors or nystagmus <small>(includes eye movements, head tremors)</small></td> </tr> <tr> <td><input type="checkbox"/> Excessive bellowing</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Excessive licking</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Excitable</td> <td></td> </tr> </table>	<input type="checkbox"/> Abnormal head carriage	<input type="checkbox"/> Head pressing / rubbing	<input type="checkbox"/> Aggressive or belligerent	<input type="checkbox"/> Head shyness	<input type="checkbox"/> Apprehension or nervous	<input type="checkbox"/> Hyperesthesia <small>(includes sensitivity to light, sudden movements to loud sounds, shifting ears)</small>	<input type="checkbox"/> Ataxia <small>(abnormal gait, uncoordinated)</small>	<input type="checkbox"/> Hesitation at doors, gates, or barriers	<input type="checkbox"/> Blindness	<input type="checkbox"/> Kicking during milking <small>(when did not before)</small>	<input type="checkbox"/> Circling	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Droopy lip or eyelid	<input type="checkbox"/> Tremors or nystagmus <small>(includes eye movements, head tremors)</small>	<input type="checkbox"/> Excessive bellowing		<input type="checkbox"/> Excessive licking		<input type="checkbox"/> Excitable		<p>If any of the signs to the left were checked, please indicate if <b>the condition was progressive</b>, meaning it worsened over time.  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know</p> <p>If any of the signs to the left were checked, please indicate if <b>the condition did not respond to treatment</b>.  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know</p> <p><b>Mark any of the signs below regardless of whether the condition was progressive:</b></p> <input type="checkbox"/> Depressed <input type="checkbox"/> Dead of unknown cause <input type="checkbox"/> Loss of weight over time <input type="checkbox"/> Recumbency <small>(includes nonambulatory/down)</small> <input type="checkbox"/> Reduced milk yield over time <input type="checkbox"/> Other <small>(provide in comments)</small>
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**FSIS Condemnation Codes (Select one – ONLY if FSIS has made one of these designations)**

<input type="checkbox"/> Degen & Dropsic 099	<input type="checkbox"/> Misc. inflamm dz. 299	<input type="checkbox"/> Injuries 605	<input type="checkbox"/> Tetanus 105
<input type="checkbox"/> Actinomycosis & Actinobacillosis 101	<input type="checkbox"/> Epithelioma 302	<input type="checkbox"/> Pigment conditions 607	<input type="checkbox"/> Vesicular dz. 110
<input type="checkbox"/> Misc. infectious dz. 199	<input type="checkbox"/> Malig lymphoma 303	<input type="checkbox"/> Myiasis 402	<input type="checkbox"/> CNS disorders 601
<input type="checkbox"/> Arthritis 201	<input type="checkbox"/> Misc. neoplasms 399	<input type="checkbox"/> General misc. 699	<input type="checkbox"/> Dead 603
<input type="checkbox"/> Mastitis 203	<input type="checkbox"/> Abscess/pyemia 501	<input type="checkbox"/> Residue 609	<input type="checkbox"/> Moribund 606
<input type="checkbox"/> Metritis 204	<input type="checkbox"/> Septicemia 502	<input type="checkbox"/> Other reportable dz. 900	<input type="checkbox"/> Pyrexia 608
<input type="checkbox"/> Pericarditis 206	<input type="checkbox"/> Toxemia 503	<input type="checkbox"/> Misc. parasitic cond. 499	<input type="checkbox"/> Rabies 615
<input type="checkbox"/> Pneumonia 208	<input type="checkbox"/> Nonambulatory 445		

**Comments:**