

# ANIMAL BLASTOMYCOSIS CASE REPORT FORM

Please fax completed form to Dr. Ireland at 651-201-5743

## A. DEMOGRAPHIC INFORMATION

Owner name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: **MN** (no need to report non-MN)  
Zip: \_\_\_\_\_ County: \_\_\_\_\_  
Phone (1): \_\_\_\_\_ Phone (2): \_\_\_\_\_  
Email: \_\_\_\_\_  
Veterinary clinic: \_\_\_\_\_

Pet's name: \_\_\_\_\_ Pet's weight (lbs): \_\_\_\_\_  
Species: \_\_\_\_\_ Breed: \_\_\_\_\_  
DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_  
Sex:  Male  Female  
Spayed/neutered:  Yes  No  
Pet is primarily:  Indoors  Outdoors  Both  
Clinic phone: \_\_\_\_\_

## B. CLINICAL ILLNESS HISTORY

Illness onset: \_\_\_\_/\_\_\_\_/\_\_\_\_

First appointment: \_\_\_\_/\_\_\_\_/\_\_\_\_

Symptoms:

Cough  Yes  No  
Coughing up blood  Yes  No  
Difficulty breathing  Yes  No  
Non-healing skin sores  Yes  No  
Poor appetite  Yes  No  
Weight loss  Yes  No #lbs. \_\_\_\_  
Lethargy  Yes  No  
Fever  Yes  No temp. \_\_\_\_F  
Seizures  Yes  No  
Blindness  Yes  No  
Lameness/limping  Yes  No

Other: \_\_\_\_\_

Has the pet been hospitalized for blasto?  Yes  No

Treatment:  Itraconazole  Fluconazole

Ketoconazole  Amphotericin B

Other: \_\_\_\_\_  None

Outcome:  Still being treated

Recovered date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Euthanized date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Died naturally date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Had the pet been previously treated for blastomycosis?

Yes  No If yes, date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## C. DIAGNOSTIC INFORMATION

Lab name (list all, if multiple): \_\_\_\_\_

	Collection date:	Specimen:	Value or findings:	Result:
Antigen (Miravista):	____/____/____	<input type="checkbox"/> Urine <input type="checkbox"/> Serum	_____	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
Cytology/Smear:	____/____/____	_____	_____	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
Culture:	____/____/____	_____	_____	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
Serology/Antibody:	____/____/____	_____	_____	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
Histopathology:	____/____/____	_____	_____	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
Radiology:	____/____/____	_____	_____	_____

## D. CASE SUMMARY

Type of blastomycosis:

- Pulmonary, disease present only in the lungs  
 Non-pulmonary, no disease in lungs  
 Disseminated, both pulmonary and non-pulmonary disease

If non-pulmonary or disseminated, please mark all locations affected:

Bone  Skin  Eye  CNS

Other location: \_\_\_\_\_

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