



Plant & Pest Diagnostic Clinic Specimen Identification Form

448 Plant Science Hall
Lincoln, NE 68583-0722

For Lab Use Only

Lab No. _____

Diagnostic Method

Visual Culture Serological

Cash Check No. _____

Amt: _____ Date: _____

Called (Date & Initials): _____

SUBMITTER

Name: _____

Business Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Cell: _____

E-mail: _____

CLIENT

Name: _____

Business Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Cell: _____

E-mail: _____

| | | |
|---|--|--|
| Mail reply to: <input type="checkbox"/> Sub. <input type="checkbox"/> Client E-mail reply to: <input type="checkbox"/> Sub. <input type="checkbox"/> Client Send bill to: <input type="checkbox"/> Sub. <input type="checkbox"/> Client | Services Requested: <input type="checkbox"/> Plant ID <input type="checkbox"/> Plant Disease <input type="checkbox"/> Insect <input type="checkbox"/> Chemical Injury <input type="checkbox"/> Weed ID <input type="checkbox"/> Nematode Assay <input type="checkbox"/> Nutrient Deficiency <input type="checkbox"/> Other/Unknown | Sample Fee: <input type="checkbox"/> Perform only basic diagnosis (\$15.00) <input type="checkbox"/> Please notify if advance analysis is needed (over \$15.00) <input type="checkbox"/> Perform advance testing needed (up to \$100.00) |
| Make checks payable to "University of Nebraska" | | |

Crop or Plant: _____ **Variety/Cultivar:** _____ **Symptoms developed in:** _____ Days _____ Weeks _____ Months

Date collected: _____ **County of Origin:** _____ Occurred in previous years _____

Trees/shrubs/ornamentals: Aprox age _____ Height: _____ Number of years at site: _____

| <u>Location</u> | <u>Incidence</u> | <u>Symptoms</u> | <u>Parts Affected</u> | <u>Distribution</u> | <u>Field History</u> |
|---|--|--|---|--|---|
| <input type="checkbox"/> Field <input type="checkbox"/> Pasture <input type="checkbox"/> Nursery/Orchard <input type="checkbox"/> Golf Course <input type="checkbox"/> Lawn/Turfgrass <input type="checkbox"/> Landscape <input type="checkbox"/> Garden <input type="checkbox"/> Home-Structural <input type="checkbox"/> Other: | _____ Acres _____ Sq. ft _____ % of area --Or-- _____ # of plants _____ % of plants | <input type="checkbox"/> Abnormal growth <input type="checkbox"/> Dead areas <input type="checkbox"/> Dieback <input type="checkbox"/> Leaf drop <input type="checkbox"/> Leaf spot <input type="checkbox"/> Rot <input type="checkbox"/> Stunted <input type="checkbox"/> Wilted <input type="checkbox"/> Yellowed <input type="checkbox"/> Other: | <input type="checkbox"/> Branches _____ % <input type="checkbox"/> Entire plant <input type="checkbox"/> Flowers <input type="checkbox"/> Fruits/seeds <input type="checkbox"/> Leaves _____ % <input type="checkbox"/> Roots <input type="checkbox"/> Stems <input type="checkbox"/> Trunk <input type="checkbox"/> Other: | <input type="checkbox"/> Certain variety <input type="checkbox"/> Edge of planting <input type="checkbox"/> General <input type="checkbox"/> High areas <input type="checkbox"/> Low areas <input type="checkbox"/> Scattered <input type="checkbox"/> Shaded areas <input type="checkbox"/> Spots <input type="checkbox"/> Sunny areas <input type="checkbox"/> Wet areas <input type="checkbox"/> Other: | Soil pH: _____ Soil Drainage: <input type="checkbox"/> Good <input type="checkbox"/> Poor Previous Crop Yr 1: _____ Yr 2: _____ Yr 3: _____ |

Planting date: _____

Chemical history: Please provide chemical name, application dates, and rates:

Fertilizer: _____

Seed treatment: _____

Herbicide: _____

Fungicide: _____

Insecticide: _____

Tillage: _____ **Irrigated:** Yes No

Please describe problem. Include any details not covered above. Attach photos if possible. (Please use reverse side for more space)