

## LIFE EUROKITE Project: Necropsy Form

<b>CASE CODE</b>					
<input style="width: 100px; height: 20px;" type="text"/> <input style="width: 100px; height: 20px;" type="text"/> <input style="width: 100px; height: 20px;" type="text"/> <input style="width: 100px; height: 20px;" type="text"/> <input style="width: 100px; height: 20px;" type="text"/>	<small>DateOfSearch(YYYYMMDD)_CountryCode__CodeOfRegion__SatelliteTagCode__ConsecutiveNumber</small>				
Date of completing: <input style="width: 40px;" type="text"/> / <input style="width: 40px;" type="text"/> / 20 <input style="width: 40px;" type="text"/>		Examiner/Lab ID/Year: <input style="width: 40px;" type="text"/> / <input style="width: 40px;" type="text"/> / 20 <input style="width: 40px;" type="text"/>			
Case Form received? <input type="checkbox"/> Yes <input type="checkbox"/> No		Bird received on: <input style="width: 40px;" type="text"/> / <input style="width: 40px;" type="text"/> / 20 <input style="width: 40px;" type="text"/>			
Case code LIFE EUROKITE: <input style="width: 100%; height: 20px;" type="text"/>					
<b>SAMPLES</b>					
Submitted samples sealed: <input type="checkbox"/> Yes <input type="checkbox"/> No					
Samples/Species: <input style="width: 100%; height: 20px;" type="text"/>					
Identification markings/ring number: <input style="width: 100%; height: 20px;" type="text"/>					
Age: <input type="checkbox"/> Juvenile <input type="checkbox"/> Adult <input type="checkbox"/> Unknown <input style="width: 40px;" type="text"/>					
Weight: <input style="width: 40px;" type="text"/> g					
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown					
Gonades: <input type="checkbox"/> Inactive <input type="checkbox"/> Active <input type="checkbox"/> Egg(s) in formation <input type="checkbox"/> Unknown					
<b>GENERAL INFORMATION</b>					
Condition of carcass: <input type="checkbox"/> Fresh <input type="checkbox"/> Good <input type="checkbox"/> Moderate <input type="checkbox"/> Bad <input type="checkbox"/> Frozen <input type="checkbox"/> Cannot be evaluated (cadaverous/mummified)					
Body condition: <input type="checkbox"/> Fresh <input type="checkbox"/> Good <input type="checkbox"/> Moderate <input type="checkbox"/> Ill-nourished <input type="checkbox"/> Cachectic <input type="checkbox"/> Cannot be evaluated					
<b>PERFORMED DIAGNOSTICS</b>					
<input type="checkbox"/> X-Rays <input type="checkbox"/> Gross pathology <input type="checkbox"/> Histology <input type="checkbox"/> Parasitology <input type="checkbox"/> Virology <input type="checkbox"/> Toxicology					
<input type="checkbox"/> Bacteriology/mycology <input type="checkbox"/> Other diagnostics: <input style="width: 100%; height: 20px;" type="text"/>					
Additional samples preserved <input type="checkbox"/> Yes <input type="checkbox"/> No					
<input type="checkbox"/> Heart <input type="checkbox"/> Lung <input type="checkbox"/> Liver <input type="checkbox"/> Spleen <input type="checkbox"/> Kidney <input type="checkbox"/> Skin <input type="checkbox"/> Brain					
<input type="checkbox"/> Stomach <input type="checkbox"/> Intestine <input type="checkbox"/> Other samples: <input style="width: 100%; height: 20px;" type="text"/>					
On behalf of: <input style="width: 100%; height: 20px;" type="text"/>					
<b>X-RAYS</b>					
<input type="checkbox"/> Done <input type="checkbox"/> Not done					
Trauma – skeletal injuries					
<input type="checkbox"/> None <input type="checkbox"/> Head <input type="checkbox"/> Spine <input type="checkbox"/> Torso <input type="checkbox"/> Right wing <input type="checkbox"/> Left wing					
<input type="checkbox"/> Right leg <input type="checkbox"/> Left leg					
Metal opacity / Evidence of gunshot					
<input type="checkbox"/> None <input type="checkbox"/> Head <input type="checkbox"/> Spine <input type="checkbox"/> Torso <input type="checkbox"/> Right wing <input type="checkbox"/> Left wing					
<input type="checkbox"/> Right leg <input type="checkbox"/> Left leg					
Precise description:					
<input style="width: 100%; height: 20px;" type="text"/>					
<input style="width: 100%; height: 20px;" type="text"/>					
<input style="width: 100%; height: 20px;" type="text"/>					
Evaluation has to be combined with gross pathology!					



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<b>GROSS PATHOLOGY</b>	<input type="checkbox"/> Done	<input type="checkbox"/> Not done	
<b>Trauma:</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Type of trauma:	<input type="checkbox"/> Blunt	<input type="checkbox"/> Pointed	<input type="checkbox"/> Others: <input type="text"/>
Trauma extent:	<input type="checkbox"/> Tissue	<input type="checkbox"/> Bone	
Location?	<input type="checkbox"/> Head	<input type="checkbox"/> Torso	<input type="checkbox"/> Spine: <input type="text"/>
	<input type="checkbox"/> Right wing	<input type="checkbox"/> Left wing	<input type="checkbox"/> Right leg <input type="checkbox"/> Left leg
Bleeding?	<input type="checkbox"/> Trauma intravital	<input type="checkbox"/> Trauma postmortal	
Precise description:	<input type="text"/> <input type="text"/> <input type="text"/>		
Evaluation:	<input type="checkbox"/> Cause of death	<input type="checkbox"/> Incidental finding	<input type="checkbox"/> Evaluation not possible
Cause of trauma (Is location of carcass correlated to cause of death?):	<input type="text"/>		
<b><u>Carcass</u></b>			
Abnormalities:	<input type="checkbox"/> Trauma listed above	<input type="checkbox"/> No abnormality detected	
<input type="checkbox"/> Coat:	<input type="text"/>		
<input type="checkbox"/> Skin	<input type="text"/>		
<input type="checkbox"/> Orifices of the body	<input type="text"/>		
<input type="checkbox"/> Eyes	<input type="text"/>		
<input type="checkbox"/> Nose and beak	<input type="text"/>		
<input type="checkbox"/> Ears	<input type="text"/>		
<input type="checkbox"/> Additional information:	<input type="text"/> <input type="text"/>		
<b><u>Musculoskeletal and central nervous system</u></b>			
Abnormalities:	<input type="checkbox"/> Trauma listed above	<input type="checkbox"/> No abnormality detected	
<input type="checkbox"/> Skeleton	<input type="text"/>		
<input type="checkbox"/> Muscles	<input type="text"/>		
<input type="checkbox"/> Brain	<input type="text"/>		
<input type="checkbox"/> Nervs	<input type="text"/>		
<input type="checkbox"/> Additional information:	<input type="text"/> <input type="text"/>		



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**GROSS PATHOLOGY – visceral cavity and organs**

Done

Not done

**Respiratory system**

Abnormalities:  Trauma listed above  No abnormality detected

Trachea/ Lung/ Air sacs

Additional information:

**Circulation**

Abnormalities:  Trauma listed above  No abnormality detected

Heart/Vessels

Additional information:

**Parenchyma**

Abnormalities:  Trauma listed above  No abnormality detected

Pancreas

Liver

Spleen

Additional information:

**Urinary tract**

Abnormalities:  Trauma listed above  No abnormality detected

Kidney

Additional information:

**Digestive tract**

Abnormalities:  Trauma listed above  No abnormality detected

Oesophagus/Crop

Filling:  Well  Moderate  Mild  Poorly  Empty

Content:  Pellet  Bones  Muscels  Others:   
 Cannot be evaluated

Stomach

Filling:  Well  Moderate  Mild  Poorly  Empty

Content:  Pellet  Bones  Muscels  Others:   
 Cannot be evaluated

Intestinal tract

Filling:  Well  Moderate  Mild  Poorly  Empty

Content:   Cannot be evaluated

Additional information



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<b>BACTERIOLOGY/MYCOLOGY</b>					<input type="checkbox"/> Done	<input type="checkbox"/> Not done	
Examined organ(s):	<input type="checkbox"/> Lung	<input type="checkbox"/> Liver	<input type="checkbox"/> Kidney	<input type="checkbox"/> Skin	<input type="checkbox"/> Intestine		
	<input type="checkbox"/> Other sample(s): _____						
Spread infection:	<input type="checkbox"/> Local	<input type="checkbox"/> Generalized					
Diagnostic findings:	_____ _____						
Portal of entry:	<input type="checkbox"/> Organ(s): _____			<input type="checkbox"/> Injury: _____			
	<input type="checkbox"/> Unknown						
Evaluation:	<input type="checkbox"/> Cause of death	<input type="checkbox"/> Incidental finding	<input type="checkbox"/> Evaluation not possible				
<input type="checkbox"/> Additional information:	_____ _____						
<b>VIROLOGY</b>					<input type="checkbox"/> Done	<input type="checkbox"/> Not done	
Examined organ(s):	<input type="checkbox"/> Lung	<input type="checkbox"/> Liver	<input type="checkbox"/> Spleen	<input type="checkbox"/> Skin	<input type="checkbox"/> Intestine		
	<input type="checkbox"/> Other sample(s): _____						
Spread infection:	<input type="checkbox"/> Local	<input type="checkbox"/> Generalized					
Diagnostic findings:	_____ _____						
Evaluation:	<input type="checkbox"/> Cause of death	<input type="checkbox"/> Incidental finding	<input type="checkbox"/> Evaluation not possible				
<input type="checkbox"/> Additional information:	_____ _____						
<b>PARASITOLOGY</b>					<input type="checkbox"/> Done	<input type="checkbox"/> Not done	
Ectoparasites:	<input type="checkbox"/> Negative	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe			
	<input type="checkbox"/> Mites	<input type="checkbox"/> Nits	<input type="checkbox"/> Louse flies	<input type="checkbox"/> Ticks	<input type="checkbox"/> Fleas		
	<input type="checkbox"/> Others: _____						
Endoparasites:	<input type="checkbox"/> Negative	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe			
	<input type="checkbox"/> Capillaria	<input type="checkbox"/> Ascaridia	<input type="checkbox"/> Cestodes	<input type="checkbox"/> Coccidia	<input type="checkbox"/> Trichomonads		
	<input type="checkbox"/> Others: _____						
Proven parasites in histology:	<input type="checkbox"/> Negative	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe			
In:	<input type="checkbox"/> Heart	<input type="checkbox"/> Lung	<input type="checkbox"/> Liver	<input type="checkbox"/> Spleen	<input type="checkbox"/> Kidneys		
	<input type="checkbox"/> Muscle	<input type="checkbox"/> Skin	<input type="checkbox"/> Brain				
	<input type="checkbox"/> Intestinal tract: _____			<input type="checkbox"/> Others: _____			
Evaluation:	<input type="checkbox"/> Cause of death	<input type="checkbox"/> Incidental finding	<input type="checkbox"/> Evaluation not possible				
<input type="checkbox"/> Additional information:	_____ _____						



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<b>TOXICOLOGY</b>		<input type="checkbox"/> Done	<input type="checkbox"/> Not done
Sample:	<input type="checkbox"/> Content of crop/oesophagus	<input type="checkbox"/> Content of stomach	<input type="checkbox"/> Liver
	<input type="checkbox"/> Others: _____		
Evidence:	<input type="checkbox"/> No substances detected	<input type="checkbox"/> Anticoagulants/Coumarin derivate	<input type="checkbox"/> Lead
	<input type="checkbox"/> Cholinesterase inhibitors (carbofuran)		
	<input type="checkbox"/> Expanded toxicological screening: _____		
Evaluation:	<input type="checkbox"/> Cause of death	<input type="checkbox"/> No definite interpretation possible	
	<input type="checkbox"/> Subclinical value/incidental finding		
<input type="checkbox"/> Additional information:			
_____			

<b>HISTOLOGY</b>		<input type="checkbox"/> Done	<input type="checkbox"/> Not done
<input type="checkbox"/> Heart	_____		
<input type="checkbox"/> Lung	_____		
<input type="checkbox"/> Liver	_____		
<input type="checkbox"/> Kidney	_____		
<input type="checkbox"/> Spleen	_____		
<input type="checkbox"/> Stomach/Intestine	_____		
<input type="checkbox"/> Brain	_____		
<input type="checkbox"/> Other samples	_____		
<b>Proven inflammation in histology:</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Affected organ(s):	<input type="checkbox"/> Heart	<input type="checkbox"/> Lung	<input type="checkbox"/> Liver
	<input type="checkbox"/> Skin	<input type="checkbox"/> Brain	<input type="checkbox"/> Stomach
	<input type="checkbox"/> Other sample:	<input type="checkbox"/> Spleen	<input type="checkbox"/> Intestine
	_____		
Cause of inflammation:	<input type="checkbox"/> Bacteria	<input type="checkbox"/> Fungi	<input type="checkbox"/> Viruses
	<input type="checkbox"/> Others:	<input type="checkbox"/> Parasites	
	_____		
Evaluation:	<input type="checkbox"/> Cause of death	<input type="checkbox"/> Incidental finding	<input type="checkbox"/> Evaluation not possible
<input type="checkbox"/> Additional information:			
_____			

<b>DIAGNOSIS</b>
_____
_____
_____
_____
_____
_____

