

Arthropod and Plant Disease Diagnostics Form

INSTRUCTIONS: Please complete all of the information in box A, then turn form over and complete EITHER box B for Insect Identification or box C for Plant Disease on the back. If you are unsure whether you have an insect or disease, please complete Section C.

A

Sample from my home Commercial sample Today's Date: _____

Name: _____

Company Name (if commercial): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax:(optional) _____

Email: (optional, may speed up response) _____

Have you previously contacted a County Extension Agent or Master Gardeners desk about this problem?
 Yes No

For Office Use Only:

DIAGNOSIS:

<p>Response</p> <p><input type="checkbox"/> Sent to: _____</p> <p><input type="checkbox"/> Phone Call</p> <p><input type="checkbox"/> Letter <input type="checkbox"/> Fax</p> <p><input type="checkbox"/> Email <input type="checkbox"/> Office Visit</p>	<p>Date: _____</p>	<p>Action Required</p> <p><input type="checkbox"/> File Only</p> <p><input type="checkbox"/> Mail</p> <p><input type="checkbox"/> Mail and attach factsheet:</p>	<p>Entomologist(s) Responding</p> <p>Michael Merchant _____</p> <p>Allen Knutson _____</p> <p>Kimberly Schofield _____</p> <p>Pathologist Responding</p> <p>Kevin Ong _____</p>
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B

INSECT / ARTHROPOD PEST DAMAGE IDENTIFICATION

Complete this section for insect or arthropod identifications.

Please note that all information is necessary for accurate problem identification and prompt response.

Date Sample Collected: _____ City: _____ County: _____

Feeding on plant Kind: _____

Feeding on animal Kind: _____

Found in or around home or structure Where: _____

Additional description, remarks on why sample being submitted, type of damage observed, other comments:

C

PLANT DISEASE PROBLEM CHECKLIST

Complete this section for plant disease identification.

Please note that all information is necessary for accurate disease identification, diagnosis, and control recommendations.

Date Sample Collected: _____ City: _____ County: _____

PLANT: _____ Total # of plants: _____ # of plants affected: _____

VARIETY or CULTIVAR: _____ Age (year) or height (feet) of affected plants: _____

Planting Date: _____ Soil pH: _____ % of area affected on the plant: _____

Please mark all that apply.

Location of plant(s): Within 10 feet (3 meters) of building, pool, pavement, or road Along Fence Row

Full sun (>6 hr sun/day) Open (>20 feet from any structure) Other: _____

Affected Part: Whole plant Branches/trunk Foliage (leaves) Flowers Fruit Roots

Symptoms: Dead plant Leaf spots Canker/gall Wilting Rot Yellowing

Stunting Burns Other: _____

Date first noticed: _____ Problem developed: Suddenly Gradually

Distribution of problem plant(s): Isolated plant(s) Scattered plants Large area Small localized area

Watering practices: Sprinklers Less than 3 times/week Hand water Daily

Drip system More than 3 times/week Variable/as needed None

Additional description, remarks on why sample being submitted, any pesticides or fertilizers used in the last 30 days, other comments: