



## HOMEOWNER PLANT DISEASE CLINIC FORM

Enter information from this sheet into the online DDDI system before shipping. DDDI will generate a PDF form with a unique sample number used to track the sample. Print the PDF form and send with the sample.

Date: \_\_\_\_\_ Client's Name: \_\_\_\_\_  
 Plant Name: \_\_\_\_\_ Address: \_\_\_\_\_  
 Plant Variety: \_\_\_\_\_

Sample Submitted by (Other than Grower/Owner): \_\_\_\_\_ Phone: \_\_\_\_\_ ( ) \_\_\_\_\_

1. Which part of the plant is showing symptoms?  Above ground     Below ground     Both above and below ground
2. Which part of the plant has been examined for symptoms?  Above ground     Below ground     Both above and below
3. Describe the abnormal plant's appearance, such as dieback, marginal leaf burn, leaf spot, wilting, chlorosis, etc. Include any addition information that may be contributing to the problem:  
 \_\_\_\_\_  
 \_\_\_\_\_

4. When planted: \_\_\_\_\_
5. When did you first notice this problem: \_\_\_\_\_
6. How has it spread since then? \_\_\_\_\_
7. Other significant problems (insects, fertility, weeds, etc.) \_\_\_\_\_
8. Number of plants grown: \_\_\_\_\_  Plants     Acres.
9. Is problem affecting:     Single plant;     Scattered plants;     Group of plants;     Most of planting
10. Percent of plants affected: \_\_\_\_\_
11. Type of irrigation: \_\_\_\_\_ Frequency: \_\_\_\_\_
12. Exposure, such as sunny, shaded, mixed? \_\_\_\_\_

Association with Terrain:	Soil Moisture:	Soil Type:	Soil Drainage:	Weather Conditions:	Temperature:
<input type="checkbox"/> No association <input type="checkbox"/> In low areas <input type="checkbox"/> In uplands <input type="checkbox"/> Near road, driveway, residence, edge of field	<input type="checkbox"/> Dry <input type="checkbox"/> Moist <input type="checkbox"/> Wet	<input type="checkbox"/> Clay <input type="checkbox"/> Loam <input type="checkbox"/> Sandy	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Dry <input type="checkbox"/> Humid <input type="checkbox"/> Wet	<input type="checkbox"/> Cold <input type="checkbox"/> Moderate <input type="checkbox"/> Hot

13. Previous Plantings One Year Ago: \_\_\_\_\_ Two Years Ago: \_\_\_\_\_  
 Problems on Previous Plantings: \_\_\_\_\_

14. Chemicals Applied (This information may help us determine disease potential. Please indicate type: fertilizers, weed killer, insecticides, or fungicides. If nothing was applied, indicate "None Applied"):  
 Chemical: \_\_\_\_\_ Rate: \_\_\_\_\_ Date Last Applied: \_\_\_\_\_  
 Chemical: \_\_\_\_\_ Rate: \_\_\_\_\_ Date Last Applied: \_\_\_\_\_  
 Chemical: \_\_\_\_\_ Rate: \_\_\_\_\_ Date Last Applied: \_\_\_\_\_

COUNTY: \_\_\_\_\_ AGENT: \_\_\_\_\_

### PUTTING KNOWLEDGE TO WORK

COLLEGE OF AGRICULTURAL AND ENVIRONMENTAL SCIENCES, COLLEGE OF FAMILY AND CONSUMER SCIENCES,  
 WARNELL SCHOOL OF FOREST RESOURCHES, COLLEGE OF VETERINARY SCIENCES