



HOMEOWNER PLANT DISEASE CLINIC FORM

Fill out this form and send with the sample

Date: _____ Client's Name: _____

Plant Name: _____ Address: _____

Plant Variety: _____

Email: _____

Phone: _____

1. Which part of the plant is showing symptoms? Above ground Below ground Both above and below ground

2. 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:

3. When planted: _____ 4. When did you first notice this problem: _____

5. How has it spread since then? _____

6. Other significant problems (insects, fertility, weeds, etc.) _____

7. Number of plants grown: _____ Plants Acres

8. Is problem affecting: Single plant; Scattered plants; Group of plants; Most of planting

9. Percent of plants affected: _____

10. Type of irrigation: _____ Frequency: _____

11. Exposure, such as sunny, shaded, mixed? _____

12. Previous Plantings One Year Ago: _____ Two Years Ago: _____
Problems on Previous Plantings: _____

13. Chemicals Applied (This information helps us determine contributing factors. 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,
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