



Number:	Date Received:	Date Served:	Name of MG:
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Client Name:	Daytime Phone:	County:	Client Contacted MG via: <input type="checkbox"/> Personal visit to office <input type="checkbox"/> Phone call <input type="checkbox"/>
Mailing Address:	City:	State/Zip:	
E-Mail Address:	Sample Provided <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of Sample <input type="checkbox"/> Physical <input type="checkbox"/> Digital	

Are you working with a landscape professional or commercial firm for indoor or outdoor spray service, landscape, nursery or soil analyst? ☐ Yes ☐ No **If you answered yes to any of these refer problem to Urban Horticulturist or WSU Extension specialist.**

Type of plant: ☐ Tree ☐ Shrub ☐ Herbaceous Perennial ☐ Vegetable ☐ Herb ☐ Other _____

Name of plant: _____

Age of plant:	Recent Transplant?	Approximate size:
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How was plant received: <input type="checkbox"/> Balled and burlapped <input type="checkbox"/> Plastic pot <input type="checkbox"/> Bare root <input type="checkbox"/> Peat/paper pot	Planting Preparation: <input type="checkbox"/> Pot/burlap removed from root ball <input type="checkbox"/> Peat/manure/compost added to back fill <input type="checkbox"/> Fertilizer applied at/after planting <input type="checkbox"/> Winter Protection	<input type="checkbox"/> Planted by landscaper <input type="checkbox"/> Planted by previous owner <input type="checkbox"/> Planted by Client <input type="checkbox"/> Other: _____
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Planting area mulched with: ☐ No mulch ☐ Grass clippings ☐ Landscape Cloth
☐ Bark mulch ☐ Rock/inorganic ☐ Other _____

Damage: Plant Parts/Pattern of Progression:
☐ Leaves/Flowers ☐ Started at bottom & moved up ☐ Started at the top and moved down ☐ Entire plant affected
☐ Structure/Fruit ☐ Only on the tips of branches ☐ Only on inside branches ☐ Only on one side [N S E W]

Expanse of Damaged Area:
☐ Scattered plants ☐ Various plants in a group ☐ Only one plant ☐ All similar plants

Irrigation Delivery

<u>System:</u>	<u>Application Process:</u>	<u>Frequency</u>	<u>Water Source:</u>
<input type="checkbox"/> Hand water	<input type="checkbox"/> Overhead broadcast	____ times/week for ____ min	<input type="checkbox"/> City Water-treated
<input type="checkbox"/> Sprinkler-(Manual Set)	<input type="checkbox"/> Per-plant emitter	<input type="checkbox"/> As needed (check soil only)	<input type="checkbox"/> Private Well
<input type="checkbox"/> Permanent Set sprinkler system	<input type="checkbox"/> Watered w/ lawn	<input type="checkbox"/> As needed (check weather only)	<input type="checkbox"/> Irrigation District
<input type="checkbox"/> Drip/soaker hose	<input type="checkbox"/> Directly at base of plant		
<input type="checkbox"/> Rill Flood	<input type="checkbox"/> At drip line		

Plant Location:

<input type="checkbox"/> Garden	<input type="checkbox"/> In full sun	<input type="checkbox"/> Nursery/greenhouse	<input type="checkbox"/> Next to paved/compacted area
<input type="checkbox"/> Lawn	<input type="checkbox"/> In shade	<input type="checkbox"/> Next to road	<input type="checkbox"/> Other _____
<input type="checkbox"/> On slope	<input type="checkbox"/> Sun Exposure [N S E W]	<input type="checkbox"/> Under eaves	_____
<input type="checkbox"/> At border line	<input type="checkbox"/> Next to house, building, fence	<input type="checkbox"/> Windy location	_____
<input type="checkbox"/> Landscape berm/mound/bed	<input type="checkbox"/> Next to pool		

Soil Conditions:

<input type="checkbox"/> Sandy	<input type="checkbox"/> caliche	<input type="checkbox"/> Soil the builder left	<input type="checkbox"/> Good drainage
<input type="checkbox"/> Loamy	<input type="checkbox"/> Rocky	<input type="checkbox"/> Shallow soil (<6")	<input type="checkbox"/> Poor drainage
	<input type="checkbox"/> Introduced topsoil	<input type="checkbox"/> Clay	<input type="checkbox"/> White crust on soil





Has client applied fertilizer, insecticides, fungicides to this or nearby plants in the last 12-18 months?:

☐ No ☐ Yes, complete details Date: _____ Product Name: _____

Rate: _____ Frequency: _____

How Applied: _____ Frequency: _____

Has client used any of the following in the last two years? When and where and how?

☐ Weed 'n Feed-type lawn products (selective herbicides) ☐ Roundup, Kleen-up, Knockout (non selective herbicides)

☐ Triox, Noxall, Spike, or other (soil sterilant) ☐ Casoron, Preen (pre-emergent treatment)

☐ Other: _____ When: _____

Where: _____ How: _____

Have any of the following happened near your affected plant or within your yard/garden in the past 3-5 years?

☐ Construction/heavy equipment movement ☐ Change of soil grade (landscaping, pool, etc)

☐ Addition of soil, organic matter or soil additives ☐ Soil disturbance, root injury

☐ Driveway/roadway paving nearby ☐ Trunk/bark injury

☐ Extreme drought (no irrigation for several months; spring/summer/fall)

Illustrate or describe the problem. Include pattern of damage.

<p>Has this plant ever had this problem before? When?</p> <p><input type="checkbox"/> Yes Date: ____/____/____</p> <p><input type="checkbox"/> No</p>	<p>When did you first notice the current problem?</p> <p>Approximate date: ____/____/____</p> <p><input type="checkbox"/> Developed very quickly <input type="checkbox"/> Is getting worse</p> <p><input type="checkbox"/> Developed gradually <input type="checkbox"/> Is not getting worse</p>
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Diagnostic Resources:

☐ Hortsense ☐ Pestsense ☐ PICOL ☐ PNW ☐ Insect ☐ Weed ☐ Plant Disease

☐ www._____.org/edu ☐ Other: _____

Diagnosis/Recommendation:

Diagnosed by: _____

Delivered by: Circle one

Handout provided? Yes or No Describe: _____ Code: _____ Phone E-mail In person