



# Cropland Pest Identification Form

Schutter Diagnostic Lab  
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Bozeman, MT 59717

Date \_\_\_\_\_  
(MM/DD/YY)

Client Name \_\_\_\_\_ Email \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Plant associated with damage \_\_\_\_\_ Variety \_\_\_\_\_

Planting date, age of plant or size \_\_\_\_\_

Comments - Describe problem and give tentative diagnosis

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Approximate date problem first appeared \_\_\_\_\_  
(MM/DD/YY)

Did the problem show up all at once?  Yes  No

Is the problem getting worse?  Yes  No

Pest Distribution:  Few  Common  Abundant  Extreme

Number of acres or % plants affected \_\_\_\_\_

Crop history last 2 years \_\_\_\_\_

History of neighboring crops \_\_\_\_\_

Degree of injury:  Light  Moderate  Severe

Degree of infestation:  Light  Moderate  Severe

Describe the pattern of pest problem in the field or area: \_\_\_\_\_

Terrain associated with the problem:  Sloped  High area  Irregular  Low area

Is edibility, forage value of interest?  Yes  No

Irrigation practices: Frequency \_\_\_\_\_ Amount \_\_\_\_\_  
 None  Drip  Overhead/hand  Sprinkler  Other \_\_\_\_\_

Could injury be related to the weather?  Yes  No

Weather conditions preceding development of the problem:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Rain<br>Date _____<br>Amount _____ | <input type="checkbox"/> Windy<br><input type="checkbox"/> Cloudy<br><input type="checkbox"/> Heavy dews<br><input type="checkbox"/> Humid | <input type="checkbox"/> Hail<br><input type="checkbox"/> Drought<br><input type="checkbox"/> Adequate moisture<br><input type="checkbox"/> Excess moisture |
| <input type="checkbox"/> Temperature _____                  |  |   |
| <input type="checkbox"/> Clear                              |  |   |

Check the plant part affected:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Leaves/needles:<br><input type="checkbox"/> Upper Surface<br><input type="checkbox"/> Lower Surface | <input type="checkbox"/> Stem/stalk<br><input type="checkbox"/> Flowers<br><input type="checkbox"/> Fruit/seed<br><input type="checkbox"/> Crown<br><input type="checkbox"/> Growing Tips | <input type="checkbox"/> Roots<br><input type="checkbox"/> Bulbs/rhizomes<br><input type="checkbox"/> Tubers<br><input type="checkbox"/> Buds<br><input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Branches/twigs  |   |   |
| <input type="checkbox"/> Petiole   |   |   |

Check the symptoms that apply:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Bleached           | <input type="checkbox"/> Frass                 | <input type="checkbox"/> Seed rot            |
| <input type="checkbox"/> Shoot/tip blight   | <input type="checkbox"/> Insect damage         | <input type="checkbox"/> Shedding/thinning   |
| <input type="checkbox"/> Insect boring      | <input type="checkbox"/> Excretions            | <input type="checkbox"/> Shot hole           |
| <input type="checkbox"/> Browning/scorched  | <input type="checkbox"/> Cast skins            | <input type="checkbox"/> Slime flux          |
| <input type="checkbox"/> Canker             | <input type="checkbox"/> Interveinal browning  | <input type="checkbox"/> Soft rot            |
| <input type="checkbox"/> Chewed             | <input type="checkbox"/> Interveinal yellowing | <input type="checkbox"/> Spotted             |
| <input type="checkbox"/> Cracked            | <input type="checkbox"/> Leaf spot             | <input type="checkbox"/> Stem rot            |
| <input type="checkbox"/> Damping off        | <input type="checkbox"/> Loose bark            | <input type="checkbox"/> Stippling/speckling |
| <input type="checkbox"/> Dead Areas         | <input type="checkbox"/> Marginal browning     | <input type="checkbox"/> Streak              |
| <input type="checkbox"/> Decayed            | <input type="checkbox"/> Marginal yellowing    | <input type="checkbox"/> Stubby roots        |
| <input type="checkbox"/> Dieback            | <input type="checkbox"/> Mottle/mosaic         | <input type="checkbox"/> Stunted             |
| <input type="checkbox"/> Distortion/curling | <input type="checkbox"/> Patches/rings/arcs    | <input type="checkbox"/> Rot                 |
| <input type="checkbox"/> Entire leaf eaten  | <input type="checkbox"/> Dead                  | <input type="checkbox"/> Webbing             |
| <input type="checkbox"/> Fasciations        | <input type="checkbox"/> Plant part gone       | <input type="checkbox"/> Wet wood            |
| <input type="checkbox"/> Frogeye            | <input type="checkbox"/> Poor growth           | <input type="checkbox"/> Wilted              |
| <input type="checkbox"/> Fruit/veg rot      | <input type="checkbox"/> Purple leaves         | <input type="checkbox"/> Witches broom       |
| <input type="checkbox"/> Galls              | <input type="checkbox"/> Root rot              | <input type="checkbox"/> Wormy fruit         |
| <input type="checkbox"/> Holes chewed       | <input type="checkbox"/> Scabby lesions        | <input type="checkbox"/> Yellowing           |
| <input type="checkbox"/> Leaf skeletonized  | <input type="checkbox"/> Seedling blight       | <input type="checkbox"/> Other _____         |

Problem distribution on the plant:

- |   |  |                                      |
|---|--|--------------------------------------|
| <input type="checkbox"/> This season's growth | <input type="checkbox"/> Top of plant      | <input type="checkbox"/> Limited     |
| <input type="checkbox"/> Last season's growth | <input type="checkbox"/> One side of plant | <input type="checkbox"/> Widespread  |
| <input type="checkbox"/> Bottom of plant      | <input type="checkbox"/> Scattered         | <input type="checkbox"/> Other _____ |

Check reason for identification:

- |  |  |                                      |
|--|--|--------------------------------------|
| <input type="checkbox"/> Biological Control    | <input type="checkbox"/> Stored Product Pest | <input type="checkbox"/> Survey      |
| <input type="checkbox"/> Damaging Crops/Plants | <input type="checkbox"/> Animal Pest         | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Regulatory Concern    | <input type="checkbox"/> Possible Immigrant  |                                      |

Agent \_\_\_\_\_ Email \_\_\_\_\_

County \_\_\_\_\_ Phone \_\_\_\_\_