

**Flowers, Trees, Shrubs, & Other Ornamentals
 Soil Information Sheet**

Date: _____

Label #: _____

For Official Lab Use Only
 Lab Sample Number:

Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ County: _____ E-mail: _____	TEST REQUESTED: <input type="radio"/> Gardener's Package (pH, Buffer pH, P, K, O.M., NO ₃) <input type="radio"/> Other _____	1 SAMPLE NAME: (i.e. Flowers, Shrubs, Etc.) _____
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2	SAMPLE AREA:	Was the sample made from a mix of 8 or more areas? <input type="checkbox"/> Yes <input type="checkbox"/> No
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3 RECOMMENDATIONS REQUESTED FOR (Please Select Only One Category Below):		
<input type="radio"/> Trees and/or Shrubs: <input type="radio"/> Roses <input type="radio"/> List Tree/Shrub Types Below: _____ _____ _____ _____ _____	<input type="radio"/> Flowers: <input type="radio"/> Annual Flowers (Marigold, Zinnia, etc.) _____ _____ <input type="radio"/> Perennial Flowers _____ _____ _____	<input type="radio"/> Ornamental Grasses: <input type="radio"/> List Types Below: _____ _____ <input type="radio"/> Other: _____ _____

4 CONDITION OF PLANT(S)	
Plant growth in sampled area: <input type="radio"/> Not planted yet <input type="radio"/> Normal <input type="radio"/> Abnormal _____ (describe)	If only a few plants show abnormal growth, list which type(s): _____ _____

5 CURRENT FERTILIZER PROGRAM (CHECK ALL THAT APPLY):		
a How often do you fertilize? <input type="radio"/> Every Year <input type="radio"/> Twice a Year <input type="radio"/> Every other Year <input type="radio"/> Never <input type="radio"/> Other _____	b When do you fertilize? <input type="radio"/> Prior to planting <input type="radio"/> During growing season <input type="radio"/> During dormant season <input type="radio"/> Other _____	c What kinds of fertilizer do you use? <input type="radio"/> High phosphorus (5-10-5, 18-46-0, etc.) <input type="radio"/> Balanced (10-10-10, 13-13-13, etc.) <input type="radio"/> High Nitrogen (33-0-0, 20-4-8, etc.) <input type="radio"/> Organic (manure, etc.) <input type="radio"/> "Starter Fertilizer" for transplants <input type="radio"/> Other _____

d How often do you add organic matter (i.e. compost, manure, grass clippings leaves, peat moss etc?) <input type="radio"/> Every year <input type="radio"/> Every other year <input type="radio"/> Twice a year <input type="radio"/> Never <input type="radio"/> Other _____ Has manure or compost recently been applied? <input type="checkbox"/> Yes <input type="checkbox"/> No	6 INDICATE ANY SPECIFIC PROBLEMS: <input type="radio"/> Insects <input type="radio"/> Disease <input type="radio"/> Poor drainage <input type="radio"/> Shade <input type="radio"/> Grassy Weeds <input type="radio"/> Broadleaf Weeds <input type="radio"/> Other (Describe) _____
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Please fill in this sheet completely. The more information you provide on this form, the more complete and helpful your soil recommendation will be to you.

Billed: _____ Paid: _____