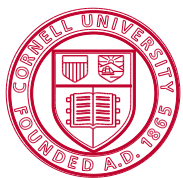


General Submission Form



Animal Health Diagnostic Center

College of Veterinary Medicine, Cornell University
In Partnership with the NYS Dept. of Ag & Markets

US Postal Service Address: PO Box 5786
Ithaca, NY 14852-5786

FedEx/UPS Service Address: 240 Farrier Rd.
Ithaca, NY 14853

AHDC Contacts
Phone: 607-253-3900
Fax: 607-253-3943
Web: ahdc.vet.cornell.edu
Email: diagcenter@cornell.edu

LAB USE ONLY

AHDC Accession No. / Date

PLEASE NOTE: SAMPLES SUBMITTED FOR TESTING BECOME THE PROPERTY OF THE ANIMAL HEALTH DIAGNOSTIC CENTER AND MAY BE TESTED AS PART OF STATE/FEDERAL SURVEILLANCE PROGRAMS

PLEASE COMPLETE ALL FIELDS, PRINT LEGIBLY, AND ENTER ONLY ONE OWNER PER FORM

Enter Your Cornell AHDC Acct. No. _____	Your Internal Case / Reference No. ** _____
Submitting Veterinarian* _____ Clinic Name _____ Address _____ City, State, Zip _____ Phone No. (____) _____ Fax No. (____) _____ Submitting Vet's Signature: _____	Owner _____ Address _____ City, State, Zip _____ Phone No. (____) _____ County _____ Town _____ NYS Premises ID _____

Check if appropriate: **Regulatory** **Export** Country of Destination _____ Shipper/Exporter _____

HISTORY/CLINICAL INFORMATION: Please check all that apply:

<input type="checkbox"/> Dermatological	<input type="checkbox"/> Fever	<input type="checkbox"/> Neurological	<input type="checkbox"/> Normal	<input type="checkbox"/> Hematological/Hemorrhage
<input type="checkbox"/> Abortion/Repro Failure	<input type="checkbox"/> Endocrine	<input type="checkbox"/> Sudden Death	<input type="checkbox"/> Hepatic	<input type="checkbox"/> Gastrointestinal/Diarrhea
<input type="checkbox"/> Edema	<input type="checkbox"/> Ocular	<input type="checkbox"/> Neoplasia	<input type="checkbox"/> Urinary/Urogenital	<input type="checkbox"/> Musculoskeletal/Lameness
<input type="checkbox"/> Respiratory	<input type="checkbox"/> Anorexia	<input type="checkbox"/> Cardiac	<input type="checkbox"/> Chronic Weight Loss	<input type="checkbox"/> Production/Performance decline
			<input type="checkbox"/> Erosion/Vesicular	<input type="checkbox"/> Other _____

Clinical / Differential Diagnosis: _____

Has related material been submitted previously for this animal(s)/herd: Y N Accession No. _____

Date of onset of Herd illness: _____ In animals submitted: _____ Herd size: _____ No. dead: _____ No. affected: _____

Additional Info / History: A detailed history must be provided to receive NYS contract pricing. Check here if history is continued on back of this page, or if add'l history is attached.

ANIMAL IDENTIFICATION						INDICATE SPECIMEN TYPE AND ANATOMIC LOCATION (if appropriate)	DATE TAKEN	TEST(S) REQUESTED (per animal) ENTER FULL NAME OF TEST
SEX CODES: M=Male, MR=Mare (equine only), MC=Castrated Male, F=Female, SF=Spayed Female AGE CODES: Y=Years, M=Months, W=Weeks, D=Days; DOB=Date of Birth	NO.	NAME / IDENTIFIER NO.	SPECIES	BREED	SEX			
	1							
	2							
	3							
	4							
	5							
	6							
	7							
	8							
	9							
	10							

Comments: _____ check if continuation page included

AHDC USE ONLY OPENED BY: _____	<input type="checkbox"/> FEDEX <input type="checkbox"/> MAIL <input type="checkbox"/> FEDEX-GRND <input type="checkbox"/> PRI MAIL <input type="checkbox"/> UPS-GRND <input type="checkbox"/> EXP MAIL <input type="checkbox"/> UPS-ND <input type="checkbox"/> OTHER: _____	DATE REC'D: _____ TIME REC'D: _____ DATE SHIPPED: _____	<input type="checkbox"/> FROZEN <input type="checkbox"/> DRY ICE <input type="checkbox"/> RM TEMP <input type="checkbox"/> COLD PACK <input type="checkbox"/> COOL <input type="checkbox"/> NONE <input type="checkbox"/> COLD <input type="checkbox"/> COMMENT: _____
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