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: FedEx/UPS Service Address:
PO Box 5786   240 Farrier Rd
Ithaca, NY 14852-5786   Ithaca, NY 14853

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

LAB USE ONLY

_____
AHDC Accession No./ Date

_____
Pathology Case Number (if any)

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* _____   **Owner** _____

Clinic Name _____   Address _____

Address _____   City, State, Zip _____

City, State, Zip _____   Phone Number (_____) _____

Phone No. (_____) _____ Fax No. (_____) _____   County _____ Town _____

Submitting Vet's Signature: _____   NYS Premises ID _____

Add'l instructions: _____

Testing purpose, if not clinical: _____

☐ **Export**   Country of Destination _____

☐ **Regulatory** Shipper/Exporter _____

Clinical / Differential Diagnosis: _____
_____ (PLEASE PROVIDE HISTORY BELOW)

Enter previous related *Accession Numbers* with *Dates*: _____

Check if related material has been submitted previously   **for this animal(s):** ☐ Y ☐ N ☐ Unknown _____
                                                          for this herd: ☐ Y ☐ N ☐ Unknown _____

HISTORY: To qualify for NY State Contract pricing (see the AHDC Test & Fee Schedule), <u>a detailed history **must** be provided</u>.

Date of onset of Herd illness: _____
In animals submitted: _____

☐ Check here if history is continued on back of this page, or if add'l history is attached.

Herd size: _____
No. dead: _____
No. affected: _____

ANIMAL IDENTIFICATION

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	AGE/DOB	SPECIMEN SUBMITTED PLEASE INDICATE SAMPLING SITE	DATE TAKEN	TEST(S) REQUESTED (per animal) PLEASE ENTER FULL NAME OF TEST
1								
2								
3								
4								
5								
6								
7								
8								
9								

Comments:

☐ *List add'l items on 2nd page*

PLEASE NOTE: SAMPLES SUBMITTED FOR TESTING BECOME THE PROPERTY OF THE ANIMAL HEALTH DIAGNOSTIC CENTER.
* The submitting veterinarian is responsible for the requested tests, fees associated with this submission, and to notify the owner of test results.

Page ___ of ___

AHDC USE ONLY
OPENED BY:
_____

☐ DHL   ☐ Mail
☐ FX   ☐ Pri Mail   DATE/TIME REC'D: _____
☐ UPS-Grnd ☐ Exp Mail
☐ UPS-ND ☐ Other: _____ SHIPPED: _____

☐ FROZEN   ☐ DRY ICE   ☐ RM TEMP
☐ NOT FROZEN   ☐ COLD PACK   ☐ COOL
☐ NONE   ☐ COLD
☐ COMMENT: _____

** If your Internal Reference No. is entered on this form, it will be used to identify this case on the test result form and on the billing statement (max. 17 character field).

DL-100 10/10