VETERINARY DIAGNOSTIC SERVICES LABORATORY
Tuskegee University
College of Veterinary Medicine
Tuskegee, AL 36088
Phone: (334) 727-8511
Fax: (334) 724-4110

GENERAL REQUEST FORM

Owner Name

Animal Name PID #

Breed Weight

Sex M MN F FS Age

Canine Feline Equine Bovine Porcine

Ovine Caprine Avian Other

Vaccination

Submitting Veterinarian

Clinic

Phone

History/Clinical Findings: (This should include signs, duration of illness, treatment and management practices, rations, and temperature range.)

For additional history attach additional sheet

Clinical Diagnosis

Necropsy

Date of Death Euthanized YES NO
Date admitted to clinic or attended by ambulatory

Color # of animals in group
# of animals sick # of animals' dead

Full Necropsy (A fee will be charged)

Cosmetic Necropsy (An additional fee will be assessed)

Teaching Necropsy (No report or images will be distributed)

Rabies Testing (A rabies testing form must also be submitted)

Disposal ONLY: With Teaching Necropsy
Without Teaching Necropsy

Hold for Pick up

Private Cremation: With Teaching Necropsy
Without Teaching Necropsy

Communal Cremation: With Teaching Necropsy
Without Teaching Necropsy

****Teaching Necropsies are performed at the discretion of the pathologist on duty****

Hematology

Date & Time of Collection

Vacutainer Needle & Syringe

Anticoagulant EDTA Heparin NaCitrate

Na Fluoride/K Oxalate Other

Panels CBC Reticulocyte Count

Knott’s Fibrinogen

Individual Tests (Specify)

Blood Chemistry

Date & Time of Collection

Vacutainer Needle & Syringe

Anticoagulant: None Heparin Other

Panels SA CHEM 10 SA CHEM 15

SA CHEM 17 LA CHEM 15

Fructosamine Cortisol

Total T4 NSAID Panel

Bile Acids Lytes

Phenobarbital Other Test (Specify)

VDSL USE ONLY Pathologist____ Technician __________________________________

Accession/Specimen # _________________ Date & Time Received ________________________ Date Processed ________________

Fecal Examination/Parasite Identification

Date & Time of Collection

Fecal Flotation EPG Baermann Other

Miscellaneous Test
Occult Blood Parasite ID

Bacteriology/Microbiology

Date & Time of Collection

Specimen Type

Specimen Source

If urine please specify Cath Voided Cysto

Treatment

Antibiotic Treatment within 72 HR: YES No

If yes, List

Aerobic Culture & Sensitivity

Anaerobic Culture & Sensitivity

Fungal Culture

Aerobic Culture ONLY

EIA (complete separate request form)

Others

Clinical Pathology

Date & Time of Collection
Type of Diagnostic Service Requested

Cytology Bone Marrow Evaluation

Fluid Analysis (Specify Tests)

Blood Smear Examination (Specify)

Other Diagnostic Services (Specify)

Description and Location of Lesion(s):

Method of Specimen Collection

Aspirate Imprint/Impression Scraping

Swab Wash/Lavage Discharge From Patient

Other Method (Describe)

Type of Specimen Submitted

Slides (Smears) Peritoneal Fluid (EDTA)

Pleural Fluid (EDTA) Cerebrospinal Fluid (EDTA)

Synovial Fluid Tracheal Wash (EDTA)

Bronchoalveolar Lavage (EDTA) Tissue (No Formalin)

Other Specimen (Describe)

Urinalysis

Date & Time of Collection

Void Catheterized Cystocentesis LA Routine Urinalysis

Other SA Urinalysis with Sedivue

Biopsy

Date & Time of Collection

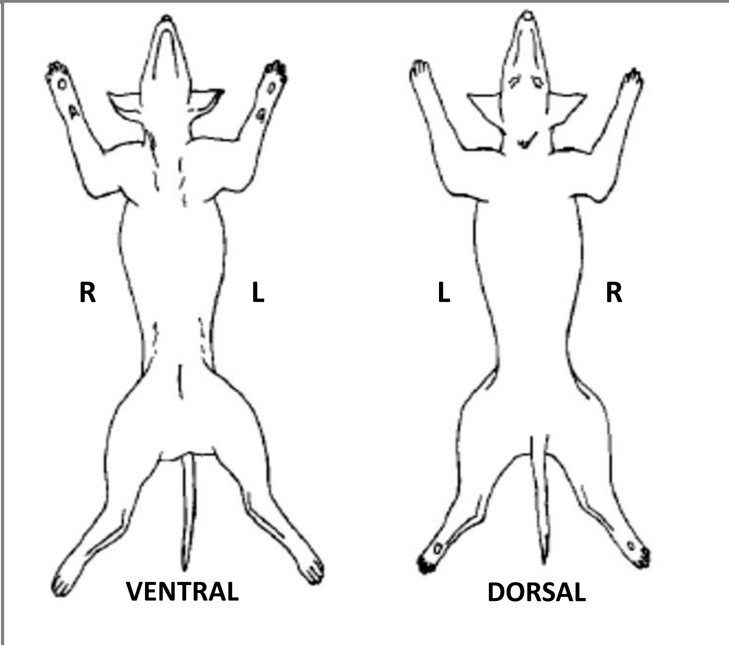
Tissue Submitted

Size cm x cm x cm

Previous Biopsy

Cytology Preformed YES NO Date:

Description of Lesion(s)



Clinician Signature ____

Intern/Student Signature____________________________________