



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
 Courier Service Address: Upper Tower Rd 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. _____ Submitting Veterinarian* _____ Clinic Name _____ Address _____ City, State, Zip _____ Phone No. (____) _____ Fax No. (____) _____ Submitting Vet's Signature: _____	Your Internal Case/Reference No.** _____ Owner _____ Address _____ City, State, Zip _____ Phone Number (____) _____ County _____ Town _____ NYS Premises ID _____
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Add'l instructions: ATTENTION: <input type="checkbox"/> Check here for test results to be faxed ; otherwise, they will be mailed.	Testing purpose, if not clinical: _____ <input type="checkbox"/> Export Country of Destination _____ <input type="checkbox"/> Regulatory Shipper/Exporter _____
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List previous related submissions here: Clinical / Differential Diagnosis: _____
 _____ PLEASE PROVIDE HISTORY

Enter previous *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), a detailed history **must** be provided.

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						SPECIMEN SUBMITTED	DATE TAKEN	TEST(S) REQUESTED
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						PLEASE INDICATE SAMPLING SITE		PLEASE ENTER FULL NAME OF TEST
NO.	NAME / IDENTIFIER NO.	SPECIES	BREED	SEX	AGE/DOB			
1								
2								
3								
4								
5								
6								
7								
8								
9								
0								

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 and fees associated with this submission.

Page ____ of ____

AHDC USE ONLY OPENED BY: _____ <input type="checkbox"/> DHL <input type="checkbox"/> Mail <input type="checkbox"/> FX <input type="checkbox"/> Pri Mail DATE/TIME REC'D: _____ <input type="checkbox"/> UPS-Grnd <input type="checkbox"/> Exp Mail <input type="checkbox"/> UPS-ND <input type="checkbox"/> Other: _____ SHIPPED: _____	<input type="checkbox"/> FROZEN <input type="checkbox"/> DRY ICE <input type="checkbox"/> RM TEMP <input type="checkbox"/> NOT FROZEN <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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