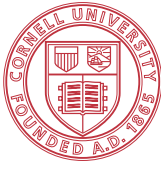


Histopathology Submission Form



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

Histopathology Contacts
 Phone: 607-253-3312 (8-4:30, M-F)
 Fax: 607-253-3357
 Web: diagcenter.vet.cornell.edu
 E-mail: diagcenter@cornell.edu

LAB USE ONLY
AHDC Accession No./ Date _____
Pathology Case Number _____

PLEASE COMPLETE ALL FIELDS, PRINT LEGIBLY, AND TYPE OR USE BLACK INK ONLY

Cornell Acct No. _____ <input type="checkbox"/> Check if URGENT! (Fee+add'l \$25.)	Your Internal Case/Reference No.** _____
Submitting Veterinarian* _____ Clinic Name _____ Address _____ City, State, Zip _____ Phone No. (_____) _____-_____ Submitting Vet's Signature: _____	Owner _____ Address _____ City, State, Zip _____ Phone Number (_____) _____ County _____ Town _____ NYS Premises ID _____

Add'l instructions: _____	ATTENTION: _____
Would you like test results reported by FAX?: Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, enter your fax number here: (_____) _____-_____ Histopathology specimens are referred to: Surgical Pathology Service, Pathology Section, Department of Biomedical Sciences, College of Veterinary Medicine, Cornell University	

ANIMAL IDENTIFICATION					HISTOPATHOLOGY SUBMISSION TYPE	POST MORTEM INTERVAL	DATE SPECIMEN TAKEN
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							
ANIMAL NAME / IDENTIFIER NO.	SPECIES	BREED	SEX	AGE/DOB			
					Biopsy <input type="checkbox"/> Post Mortem <input type="checkbox"/>		

HISTORY: <i>Clinical history required.</i> Give detailed information regarding affected animal. (NY State Contract pricing may apply; see AHDC Test & Fee Schedule.) General (Clinical presentation, treatment, etc.) Description of lesion(s) (Describe location, distribution, size, color, consistency): Clinical Diagnosis: _____ Tissues Submitted: _____ Has previous material been submitted for this problem? YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN <input type="checkbox"/> If so, enter Date(s): _____ Histopathology Nos.: _____	Date: onset of illness: _____ In animals submitted: _____ Herd size: _____ No. dead: _____ No. affected: _____ <input type="checkbox"/> Check here if add'l history is on back or attached.
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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 for notifying the owner of test results.

LAB USE ONLY	
NON-CONTRACT <input type="checkbox"/> CONTRACT <input type="checkbox"/> No. cassettes prepared: _____ No. tissues prepared: _____ Additional AHDC testing requested: _____ Special Stains: _____ Comments: _____	<input type="checkbox"/> TISSUES RECEIVED FIXED <input type="checkbox"/> TISSUES RECEIVED UNFIXED <input type="checkbox"/> UNFIXED TISSUES FIXED ON: Date: _____ Time: _____ Receipt Status of Unfixed Tissue: <input type="checkbox"/> FROZEN <input type="checkbox"/> NOT FROZEN COMMENT: _____
OPENED BY: _____ <input type="checkbox"/> DHL <input type="checkbox"/> Mail DATE AND TIME REC'D: _____ <input type="checkbox"/> FX <input type="checkbox"/> Pri Mail <input type="checkbox"/> UPS-Grnd <input type="checkbox"/> Exp Mail <input type="checkbox"/> UPS-ND SHIPPED: _____ <input type="checkbox"/> Other: _____	