

SAMPLES TAKEN Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ (yyyy/mm/dd) Time of day \_\_\_\_:\_\_\_\_ Date sent \_\_\_\_/\_\_\_\_/\_\_\_\_ (yyyy/mm/dd)  
SUBMITTED BY  Veterinarian  Owner  Agent BILL  Veterinarian  Agent

**Important. Please read.** Contact Information must be supplied with all samples submitted for testing to the Animal Health Lab ("AHL"). Agricultural animal testing carried out through AHL is subsidized by the Government of Ontario. By submitting samples for testing to AHL, the submitter acknowledges that s/he is the owner or is a duly authorized agent of the owner. The submitter acknowledges and agrees that AHL may share test results and contact information as it deems necessary for the purposes of relevant legislation regarding reportable or notifiable diseases and for the purpose of surveillance of animal or public health in Ontario.

Clinic No.	Owner Unique ID (max. 40 characters)		
Clinic			
Address	Postal Code	Address	
City	Phone	Premises ID	Barn Postal Code
Veterinarian	Fax	Phone	Email
Email	Farm		Fax
Project	Barn/Pen/Floor/Batch ID		

**\*\*\*DEMOGRAPHIC INFORMATION IMPORTANT\*\*\***

Species _____	Herd Size _____	Commodity (check) Ruminant <input type="checkbox"/> Meat <input type="checkbox"/> Dairy <input type="checkbox"/> Other _____ Swine <input type="checkbox"/> Sow <input type="checkbox"/> Finisher <input type="checkbox"/> Nursery/Weaner <input type="checkbox"/> Boar <input type="checkbox"/> Other _____ Chicken <input type="checkbox"/> Broiler <input type="checkbox"/> Layer <input type="checkbox"/> Broiler-breeder <input type="checkbox"/> Layer-breeder <input type="checkbox"/> Exhibition <input type="checkbox"/> Small Farm Turkey <input type="checkbox"/> Breeder <input type="checkbox"/> Meat <input type="checkbox"/> Exhibition <input type="checkbox"/> Small Farm
Breed _____	No. at risk _____	
Age _____ <input type="checkbox"/> d <input type="checkbox"/> w <input type="checkbox"/> m <input type="checkbox"/> y	No. sick _____	
Sex <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> N	No. dead _____	
Animal ID _____ <small>For additional animals please add extra page or send Excel spreadsheet, ahlinfo@uoguelph.ca</small>	Weight _____ kg	
Duration of problem ____ days ____ weeks ____ months ____ years		

Animals submitted	#live	#dead	#fetus	<input type="checkbox"/> Placenta	<input type="checkbox"/> Other specimens
Date/time of death	<input type="checkbox"/> Died or <input type="checkbox"/> Euthanized/method				

**CLINICAL HISTORY** List clinical problems (e.g. nervous, diarrhea, pneumonia, etc.)

1	3
2	4

Relevant History (include date(s) of onset of problems)	<input type="checkbox"/> Rabies suspect? <input type="checkbox"/> Insurance claim? <input type="checkbox"/> Possible litigation?
Clinical pathology	<b>Private Cremation?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> POSSIBLE <input type="checkbox"/> SPECIFIC INSTRUCTIONS _____ _____
Summary of recent therapy	
Vaccinations	
Management (housing, nutrition, etc.)	<input type="checkbox"/> Resubmission/Quote# _____

**Any questions? Please contact the lab.**

Email: ahlinfo@uoguelph.ca Website: http://ahl.uoguelph.ca AHL GUELPH: 519-824-4120 ext: 54530, Fax: 519-827-0961 AHL KEMPTVILLE: 613-258-8320, Fax: 613-258-8324	AHL - Guelph Courier Address UoG Animal Health Lab-PAHL 419 Gordon Street-Bldg 89 Guelph, ON N1G 2W1 Attn: Specimen Reception	Animal Health Laboratory Laboratory Services Division Univ of Guelph/Kemptville Campus 79 Shearer Street Kemptville, Ontario K0G 1J0
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Pathologist (print) \_\_\_\_\_

Date/time postmortem began: dd/mm/yyyy      00:00:00      Body weight      kg

Animal identification (CCIA #, tag, tattoo, markings, etc.) \_\_\_\_\_

**External findings**

Body condition \_\_\_\_\_ hydration \_\_\_\_\_ fat stores \_\_\_\_\_ muscle mass \_\_\_\_\_

**Internal findings**

**Clinical problems answered at postmortem (list)**

<b>POSTMORTEM DIAGNOSIS</b> <input type="checkbox"/> Tentative <input type="checkbox"/> Final	Time postmortem completed _____ Telephoned _____    Date/time _____
<input type="checkbox"/> Photos taken <input type="checkbox"/> Radiographs taken <input type="checkbox"/> Legal case-additional charges apply <input type="checkbox"/> Out of hours charges applied	Pathologist _____ <b>DVM</b>

**TESTS REQUESTED**

Bact	Mycoplasma	Parasitology	Histo
Virology	Clin path	Toxi	Other
		Serology/Immunology	Hold