



Prairie Diagnostic Services Inc.
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PDS Lab # _____
 Date/Time (received) _____
 Clinic # _____

CAPRINE OVINE SUBMISSION FORM * Required Fields

Clinic*: _____ Address: _____ Postal Code: _____ Phone: _____ Veterinarian*: _____ Email: _____ Copy to: Name _____ Copy to: Email _____	Owner/Farm Name*: _____ Location/Premise ID*: _____ Barn ID: _____ Species*: _____ Breed*: _____ Animal ID*: _____ <small>For Multiple Animals include a Multi Animal Form</small> Age*: _____ Age Unit*: _____ Sex*: _____
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STAT (fees apply)
 Rabies Suspect
 Legal Case
 Insurance Case
 Date Collected*: _____

Commodity: _____ Prod. Stage: _____ REASON FOR SUBMISSION Reason#1: _____ Reason#2: _____ PRIMARY SYSTEMS AFFECTED System#1: _____ System#2: _____ System#3: _____	Invoice to _____ Purchase Order Number: _____ (if applicable) Incident Identifier: _____ HISTORY: (include pertinent history, vaccination history, treatments, disease suspected, tentative diagnosis)																																											
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:15%;">Samples</th> <th style="width:15%;">Samples Sent*</th> <th style="width:70%;">Received office use only</th> </tr> </thead> <tbody> <tr><td>On Cells</td><td></td><td></td></tr> <tr><td>Serum</td><td></td><td></td></tr> <tr><td>EDTA</td><td></td><td></td></tr> <tr><td>Heparin</td><td></td><td></td></tr> <tr><td>Slide</td><td></td><td></td></tr> <tr><td>Fluid</td><td></td><td></td></tr> <tr><td>Fresh Tissue</td><td></td><td></td></tr> <tr><td>Fixed Tissue</td><td></td><td></td></tr> <tr><td>Whole Body</td><td></td><td></td></tr> <tr><td>Feces</td><td></td><td></td></tr> <tr><td>Swab</td><td></td><td></td></tr> <tr><td>Urine</td><td></td><td></td></tr> <tr><td>Other</td><td></td><td></td></tr> </tbody> </table>	Samples	Samples Sent*	Received office use only	On Cells			Serum			EDTA			Heparin			Slide			Fluid			Fresh Tissue			Fixed Tissue			Whole Body			Feces			Swab			Urine			Other			Herd size: _____ #Sick: _____ #Dead: _____ Previous PDS Case Number: _____ Submitters Signature: _____ Swab / Tissue Sites: _____	
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Chemistry Panels <input type="checkbox"/> Standard <input type="checkbox"/> Kidney <input type="checkbox"/> Presurgical <input type="checkbox"/> Liver <input type="checkbox"/> Single Chemistry: _____ <input type="checkbox"/> Other: _____ Hematology <input type="checkbox"/> CBC <input type="checkbox"/> Other: _____ Urine Collection Method: _____ <input type="checkbox"/> Urinalysis <input type="checkbox"/> Culture Cytology <input type="checkbox"/> Fluid <input type="checkbox"/> Smear Site: _____ Endocrine <input type="checkbox"/> BioPRYN	Bacteriology/Mycology Specimen & Site: _____ <input type="checkbox"/> Routine Culture & Susceptibility <input type="checkbox"/> Check for MIC <input type="checkbox"/> Fungal Culture <input type="checkbox"/> Anthrax Culture <input type="checkbox"/> Salmonella Screening <input type="checkbox"/> Clostridium Fluorescent Antibody Test <input type="checkbox"/> Other: _____ Parasitology <input type="checkbox"/> Routine Flotation <input type="checkbox"/> Modified Wisconsin <input type="checkbox"/> Mite and Arthropod Examination (KOH) <input type="checkbox"/> Giardia/Cryptosporidium FA and Routine Float <input type="checkbox"/> Other: _____ Immunology <input type="checkbox"/> IHC - Stain: _____ <input type="checkbox"/> Scrapie <input type="checkbox"/> Other: _____	PCR <input type="checkbox"/> Campylobacter sp. <input type="checkbox"/> Coxiella burnetti <input type="checkbox"/> Chlamydia abortus <input type="checkbox"/> Clostridium perfringens <input type="checkbox"/> Mycobacterium avium ssp. paratuberculosis (Johne's) <input type="checkbox"/> Pooled <input type="checkbox"/> Mycoplasma sp. Serology <input type="checkbox"/> Johne's (Mycobacterium paratuberculosis) <input type="checkbox"/> Caprine Arthritis and Encephalitis (CAE) ELISA <input type="checkbox"/> Ovine Progressive Pneumonia (OPP) ELISA Referred Out Tests <small>USA referrals: contact PDS for USA shipping documents</small> <input type="checkbox"/> Corynebacterium pseudotuberculosis Antibody SHI (Caseous lymphadenitis) <input type="checkbox"/> Other: _____	Toxicology Mineral Panel: <input type="checkbox"/> #1 <input type="checkbox"/> #2 <input type="checkbox"/> #3 <input type="checkbox"/> #4 <input type="checkbox"/> Single Mineral: _____ Vitamin A <input type="checkbox"/> Blood <input type="checkbox"/> Liver Vitamin E <input type="checkbox"/> Blood <input type="checkbox"/> Liver <input type="checkbox"/> Vitamin A & E <input type="checkbox"/> Vitamin D (blood only) <input type="checkbox"/> Cholinesterase (brain / blood) <input type="checkbox"/> Methemoglobin <input type="checkbox"/> Nitrite (serum / ocular fluid) <input type="checkbox"/> Other: _____ Virology <input type="checkbox"/> Other: _____ Necropsy, Surgical and Histology <input type="checkbox"/> complete Page 2
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Clinic: _____	Owner: _____
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NECROPSY AND/OR HISTOLOGY SUBMISSION

Signs of sickness: _____

Date of death: _____ Euthanasia: method/route: _____

If abortion: Age of dam: _____ Estimated age of fetus: _____ Breeding: (AI/Natural) _____ Number aborted: _____

Circle all tissue type(s) submitted and indicate the number of each sent:

Fixed Tissues: ___ Lung ___ Liver ___ Spleen ___ Kidney ___ LN ___ Ileum ___ Other _____

Fresh Tissues: ___ Lung ___ Liver ___ Spleen ___ Kidney ___ LN ___ Ileum ___ Other _____

Lab Test(s) Requested: 1) _____ 2) _____ 3) _____ 4) _____

Would you like to include additional photos? _____

Gross Necropsy Notes:

SURGICAL BIOPSY SUBMISSION

Number of formalized tissue biopsies: _____

Description: _____

Number of fresh tissue biopsies: _____

Description: _____