

R Post Due _____	FedEx Post Due _____	<input type="checkbox"/> US MAIL
Postmark _____	Postage Due _____	<input type="checkbox"/> UPS
Refrigerated _____	Not Refrig. _____	<input type="checkbox"/> FEDEX
<input type="checkbox"/> AFIN	<input type="checkbox"/> AFOUT	<input type="checkbox"/> OWNER
(laboratory use only)		<input type="checkbox"/> VET
		<input type="checkbox"/> COURIER
		<input type="checkbox"/> OTHER

**OKLAHOMA ANIMAL DISEASE  
DIAGNOSTIC LABORATORY**

**OKLAHOMA STATE UNIVERSITY** OADDL

Case No. \_\_\_\_\_

P.O. BOX 7001, STILLWATER, OK 74076 (US Mail Only)

RIDGE RD. AND FARM RD., STILLWATER, OK 74078 (UPS, FedEx, Etc.)

TELEPHONE: 405-744-6623 FAX: 405-744-8612

WEB: WWW.CVHS.OKSTATE.EDU/OADDL

**FILL OUT COMPLETELY IN BLACK INK**

OADDL Acct. No. \_\_\_\_\_

**Owner** \_\_\_\_\_  
 Farm/Company \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_  
 Date Collected \_\_\_\_\_ Date Submitted \_\_\_\_\_  
 Location of case (county/state) \_\_\_\_\_

**Veterinarian** \_\_\_\_\_  
 Clinic \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_  
 Email address \_\_\_\_\_

Bill to:  Vet  Owner  Third Party

**Report to Third Party** \_\_\_\_\_  
 Company \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_

Report Results:  Mail  Fax(\$1/Case)  Email

Animal insured?  Yes  No

Litigation possible?  Yes  Unlikely

**HISTORY**

Animal ID \_\_\_\_\_ Species \_\_\_\_\_ Breed \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ day mo. yr. Weight \_\_\_\_\_  
 Number in Group \_\_\_\_\_ Number Sick (excluding dead) \_\_\_\_\_ Number Dead \_\_\_\_\_ Raised on Premises?  Yes  No  
 If purchased, when? \_\_\_\_\_ Recent introductions?  Yes  No Date introduced \_\_\_\_\_ If an abortion, which trimester? 1 2 3  
 Date first noticed sick \_\_\_\_\_ Euthanized?  Yes  No Method used \_\_\_\_\_  
 Time & Date of Death \_\_\_\_\_ Previous submissions?  Yes  No OADDL Accession # \_\_\_\_\_  
 Clinical signs/postmortem findings: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Treatment Details \_\_\_\_\_ (Please attach additional sheet if necessary)

Vaccination History (Give details) \_\_\_\_\_

Field Diagnosis: \_\_\_\_\_ Rabies Suspected?  Yes  No

✓ MATERIALS SUBMITTED*	How Submitted?		QTY
	Fresh	Fixed	
<input type="checkbox"/> Live Animal	_____	_____	_____
<input type="checkbox"/> Dead Animal	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Fetus	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Tumor	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Skin Biopsy (see back)	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Kidney	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Liver	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Intestine <input type="checkbox"/> Stomach	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Lung	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Spleen	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Brain	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Lymph Node	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Blood <input type="checkbox"/> Clotted <input type="checkbox"/> Anticoag.	_____	_____	_____
<input type="checkbox"/> Serum	_____	_____	_____
<input type="checkbox"/> Milk	_____	_____	_____
<input type="checkbox"/> Eyeball <input type="checkbox"/> Aqueous Humor	_____	_____	_____
<input type="checkbox"/> Urine <input type="checkbox"/> Cysto <input type="checkbox"/> Voided <input type="checkbox"/> Cath.	_____	_____	_____
<input type="checkbox"/> Stomach Contents	_____	_____	_____
<input type="checkbox"/> Swab	_____	_____	_____
<input type="checkbox"/> Smear	_____	_____	_____
<input type="checkbox"/> Feed	_____	_____	_____
<input type="checkbox"/> Water	_____	_____	_____
<input type="checkbox"/> Feces	_____	_____	_____
<input type="checkbox"/> Fluid	_____	_____	_____
<input type="checkbox"/> Other	_____	_____	_____

\*If legal or other conditions warrant, duplicate samples should be retained by submitter.

**✓ TESTS REQUESTED**

Ⓢ OADDL assumes submitter gives permission to forward samples to reference subcontractors for tests not currently available within OADDL unless noted at right.  NO, do not forward my specimens to an outside reference contractor without notification.

Necropsy  Clinical Pathology  
 Histopathology\*\* (if skin biopsy, see back)  CBC  Profile  Other \_\_\_\_\_  
 Short Report  Detailed Report  Rabies  
 Immunohistochemistry \_\_\_\_\_  Serology† (see back)  
 Bacteriology† ††  Toxicology†† (see back)  
 Antibiotic Sensitivity  Virology†  
 Mycoplasma Isolation† ††  Fluorescent Antibody \_\_\_\_\_  
 Mycology† ††  ELISA (rota or parvo) \_\_\_\_\_  
 Cytology  Virus Isolation \_\_\_\_\_  
 Parasitology  Other \_\_\_\_\_

\*\* Frozen Tissues not suitable.  
 † Ship refrigerated.  
 †† Formalin fixed tissues not suitable.

BVD ELISA  
 Electron Microscopy†  
 PCR†

LAB COMMENTS: \_\_\_\_\_

