

2150 Georgetown Road Lexington, KY 40511
 Phone: 859-233-0331 Fax: 859-280-3489

VETERINARIAN: _____

PATIENT: _____

ADDRESS: _____

CLIENT/OWNER: _____

SPECIES:

PHONE/FAX: _____

EQUINE FELINE CANINE

E-MAIL _____

OTHER: _____

PLEASE CHECK TEST REQUIRED: **SPECIMENS SUBMITTED: HOW MANY?**

<p>HEMATOLOGY</p> <p><input type="checkbox"/> Complete CBC (Fib/Diff)</p> <p><input type="checkbox"/> CBC (Fib) Pre-Surgery</p> <p><input type="checkbox"/> CBC</p> <p>SINGLE HEMATOLOGY</p> <p><input type="checkbox"/> WBC</p> <p><input type="checkbox"/> RBC</p> <p><input type="checkbox"/> Hgb</p> <p><input type="checkbox"/> Hct/PCV</p> <p><input type="checkbox"/> MCV</p> <p><input type="checkbox"/> MCH</p> <p><input type="checkbox"/> MCHC</p> <p><input type="checkbox"/> Platelet</p> <p><input type="checkbox"/> TP</p> <p>FLUID ANALYSIS</p> <p>Sample Site/Type _____</p> <p><input type="checkbox"/> WBC</p> <p><input type="checkbox"/> RBC</p> <p><input type="checkbox"/> TP</p> <p>MICROBIOLOGY</p> <p>Sample Site _____</p> <p><input type="checkbox"/> Culture/Sensitivity</p> <p><input type="checkbox"/> Cytology</p> <p><input type="checkbox"/> ARD</p> <p><input type="checkbox"/> Anaerobic</p> <p>Mycology/Fungal</p> <p>FECAL SAMPLE</p> <p><input type="checkbox"/> Salmonella</p> <p><input type="checkbox"/> Float</p> <p><input type="checkbox"/> C. diff</p> <p><input type="checkbox"/> C. perf</p> <p><input type="checkbox"/> Rotavirus</p> <p><input type="checkbox"/> Occult Blood</p> <p><input type="checkbox"/> URINALYSIS</p>	<p>SERUM CHEMISTRY</p> <p><input type="checkbox"/> Master Panel</p> <p><input type="checkbox"/> Basic Panel</p> <p>SINGLE CHEMISTRY</p> <p><input type="checkbox"/> BUN</p> <p><input type="checkbox"/> Creat</p> <p><input type="checkbox"/> SGOT/AST</p> <p><input type="checkbox"/> T Bili</p> <p><input type="checkbox"/> D Bili</p> <p><input type="checkbox"/> ALP/SAP</p> <p><input type="checkbox"/> LDH</p> <p><input type="checkbox"/> CK</p> <p><input type="checkbox"/> SDH</p> <p><input type="checkbox"/> GGT</p> <p><input type="checkbox"/> Alb</p> <p><input type="checkbox"/> Ca</p> <p><input type="checkbox"/> Phos</p> <p><input type="checkbox"/> Glucose</p> <p><input type="checkbox"/> Bile Acids</p> <p><input type="checkbox"/> Lipase</p> <p><input type="checkbox"/> Amylase</p> <p><input type="checkbox"/> Triglycerides</p> <p><input type="checkbox"/> Cholesterol</p> <p><input type="checkbox"/> NH3</p> <p><input type="checkbox"/> Lactate</p> <p><input type="checkbox"/> Mg</p> <p>ELECTROLYTES</p> <p><input type="checkbox"/> Na</p> <p><input type="checkbox"/> K</p> <p><input type="checkbox"/> Cl</p> <p><input type="checkbox"/> HCO3</p> <p><input type="checkbox"/> Ca++</p> <p>ADDITIONAL TESTS:</p> <p>_____</p> <p>_____</p>	<p>ANTIBIOTIC LEVELS</p> <p>Gentamicin Peak <input type="checkbox"/> Trough <input type="checkbox"/></p> <p>Amikacin Peak <input type="checkbox"/> Trough <input type="checkbox"/></p> <p>IMMUNOPHORESIS</p> <p><input type="checkbox"/> IgG</p> <p><input type="checkbox"/> IgA</p> <p><input type="checkbox"/> IgM</p> <p><input type="checkbox"/> IgG(t)</p> <p>ANALYTE ASSAY</p> <p><input type="checkbox"/> Progesterone</p> <p><input type="checkbox"/> Testosterone</p> <p><input type="checkbox"/> T4</p> <p><input type="checkbox"/> TT3</p> <p><input type="checkbox"/> Cortisol</p> <p><input type="checkbox"/> Insulin</p> <p><input type="checkbox"/> BLOOD GAS ANALYSIS</p> <p>CLOTTING PROFILE</p> <p><input type="checkbox"/> PT</p> <p><input type="checkbox"/> PTT</p> <p><input type="checkbox"/> Platelet Count</p> <p>NI SCREEN</p> <p><input type="checkbox"/> Type/Antibody</p> <p><input type="checkbox"/> Blood Type</p> <p><input type="checkbox"/> Antibody Screen</p> <p>COGGINS/EIA</p> <p><input type="checkbox"/> AGID (24 hrs)</p> <p><input type="checkbox"/> ELISA (2hrs)</p> <p><input type="checkbox"/> Online GVL</p> <p>OTHER TESTS</p> <p><input type="checkbox"/> Coombs Test</p> <p><input type="checkbox"/> Heartworm/Lyme/Ehrlichia</p> <p><input type="checkbox"/> Feleuk/FIV</p>
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<input type="checkbox"/> Blood whole	_____
<input type="checkbox"/> Cerebrospinal Fluid	_____
<input type="checkbox"/> Culturette (origin _____)	_____
<input type="checkbox"/> Feces	_____
<input type="checkbox"/> Milk	_____
<input type="checkbox"/> Plasma EDTA	_____
<input type="checkbox"/> Plasma Heparin	_____
<input type="checkbox"/> Abscess (specify _____)	_____
<input type="checkbox"/> TransTracheal Wash	_____
<input type="checkbox"/> Serum	_____
<input type="checkbox"/> Skin Scraping	_____
<input type="checkbox"/> Smear (specify _____)	_____
<input type="checkbox"/> Synovial Fluid (specify _____)	_____
<input type="checkbox"/> Other Sterile Body Fluid (specify _____)	_____
<input type="checkbox"/> Urine	_____
<input type="checkbox"/> Other (specify _____)	_____

LAB USE ONLY
Received by: