

**Illinois Department of Agriculture and University of Illinois Veterinary Diagnostic Laboratories**

**Animal Disease Lab, Centralia**  
 9732 Shattuc Road  
 Centralia, IL 62801-5858  
 (618) 532-6701 Fax 532-1195

**Animal Disease Lab, Galesburg**  
 2100 South Lake Storey Road  
 Galesburg, IL 61401-2100  
 (309) 344-2451 Fax 344-7358

**Veterinary Diagnostic Laboratory**  
 University of Illinois, PO Box U  
 2001 S Lincoln Av; Urbana, IL 61801  
 (217) 333-1620 Fax 244-2439

Send Results by: <input type="checkbox"/> Mail <input type="checkbox"/> Fax <input type="checkbox"/> Other <input type="checkbox"/> Copy of report to: <input type="checkbox"/> Owner <input type="checkbox"/> 3 <sup>rd</sup> Party (See back) <input type="checkbox"/> Bill third party (Available from U of I only; see back of form)	<b>Laboratory Use ONLY</b> Accession # _____ Date Rec'd _____ Lab Assignment _____
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Clinic Name _____ Veterinarian _____ Clinic/Vet ID _____ Address _____ City _____ ST _____ Zip _____ Phone ( ) _____ Fax _____ FEIN _____ Acct/PO # _____	Owner _____ Address _____ City _____ County _____ State _____ Zip _____ Location of animals _____ City _____ County _____ State _____ Zip _____
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**ANIMAL INFORMATION:** Species: \_\_\_\_\_ Breed: \_\_\_\_\_ Sex: M F NM SF  
 Age: \_\_\_\_\_ Wt.: \_\_\_\_\_ Animal ID (name, tag #): \_\_\_\_\_  Purchased  Home raised  
 Euthanized If so what method \_\_\_\_\_ Date & Time of death: \_\_\_\_\_  
 # Sick: \_\_\_\_\_ # Dead: \_\_\_\_\_ # in Group: \_\_\_\_\_ # on Premises: \_\_\_\_\_ Duration of Problem: \_\_\_\_\_

**HOUSING:**  Household  Kennel  Confinement  Pastured  Feedlot  Stabled  
 Farrowing/lambing/calving, etc.  Nursery  Grower  Finisher Other: \_\_\_\_\_

**PRESENTING COMPLAINT OR SYNDROME** (Please indicate the primary clinical problem(s) in the animal(s) submitted)

<input type="checkbox"/> Abortion _____	<input type="checkbox"/> Musculoskeletal _____	<input type="checkbox"/> Respiratory _____	<input type="checkbox"/> Unthriftiness _____
<input type="checkbox"/> Skin _____	<input type="checkbox"/> Neurologic _____	<input type="checkbox"/> Tumor/Neoplasia _____	<input type="checkbox"/> Urinary _____
<input type="checkbox"/> Diarrhea/Enteric _____	<input type="checkbox"/> Reproductive _____	<input type="checkbox"/> Unexpected death _____	<input type="checkbox"/> Other _____

**Brief History/Differential Diagnoses** (More room on back) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**SPECIMENS SUBMITTED:** Whole animals/carcasses: #Live \_\_\_\_\_ #Dead \_\_\_\_\_ #Fetuses \_\_\_\_\_

#Refrig	#Refrig	#Refrig	#Fixed	#Refrig	#Fixed	#Refrig	#Fixed
Blood, whole _____	Serum * _____	Brain _____	_____	Liver _____	_____	Skin biopsy _____	_____
Feces _____	Stom conts _____	Heart _____	_____	LN, mes _____	_____	Spleen _____	_____
Feed/water _____	Thor fluid _____	Intest, lg _____	_____	LN, other _____	_____	Tonsil _____	_____
Milk _____	_____	Intest, sm _____	_____	LN, resp _____	Lung _____	Tumor _____	_____
Ocular fluid _____	_____	Kidney _____	_____	_____	_____	_____	_____

\*Please attach serology forms as needed to identify samples and animals.

**TESTS REQUESTED:** (Unless *Discretion of lab* is marked, ONLY indicated tests will be done. Additional boxes may be marked for special consideration.)

<input type="checkbox"/> Discretion of the laboratory _____	<input type="checkbox"/> Bacterial culture _____	<input type="checkbox"/> Virology _____
<input type="checkbox"/> Necropsy, gross only _____	<input type="checkbox"/> Save isolates _____	<input type="checkbox"/> Serology _____
<input type="checkbox"/> Histopathology _____	<input type="checkbox"/> Fungal culture _____	<input type="checkbox"/> Toxicology _____
<input type="checkbox"/> Clin Path _____	<input type="checkbox"/> Parasitology _____	<input type="checkbox"/> _____

**Submitting veterinarian's signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

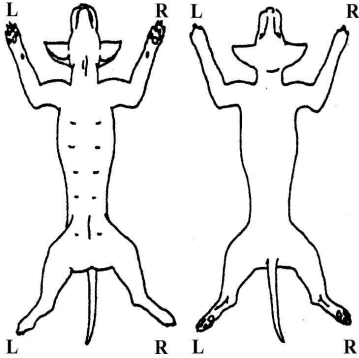
**THIRD PARTY INFORMATION:** (See front. Third party billing available ONLY from U of I Veterinary Diagnostic Lab)

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Address \_\_\_\_\_

City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_  
 Telephone (\_\_\_\_\_) \_\_\_\_\_

**ADDITIONAL HISTORY:** (Clinical signs, necropsy findings, treatment and response, antibiotic use, lab results, etc.)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

BIOPSY SPECIMEN SURGICAL PATH	Tumor A	Tumor B	Tumor C
 <p>Indicate the location of ALL biopsy sites on the anatomical diagram above. Use A, B, C, etc. to indicate each site and add additional information on the chart to the right.</p>	Location	Location	Location
	Size, shape	Size, shape	Size, shape
	Color, texture, encapsulation	Color, texture, encapsulation	Color, texture, encapsulation
	Expansile, invasive, pedunculated	Expansile invasive, pedunculated	Expansile, invasive, pedunculated
	Duration	Duration	Duration
	Growth rate	Growth rate	Growth rate
	Margins submitted?	Margins submitted?	Margins submitted?
	Recurrence?	Recurrence?	Recurrence?
Previous accession number	Previous accession number	Previous accession number	

**SPECIMENS FOR RABIES EXAMINATION**

**Animal Information:** Species: \_\_\_\_\_ Breed: \_\_\_\_\_ Sex: M F NM SF  
 Age: \_\_\_\_\_ Wt.: \_\_\_\_\_ Animal ID (name, tag #): \_\_\_\_\_ Color: \_\_\_\_\_  
 Animal died?  Killed/ethanitized? Clinical signs: \_\_\_\_\_  
 Vaccinated for rabies?  Yes  No Product \_\_\_\_\_ Date of vaccination \_\_\_\_\_

Owner _____ Address _____ City _____ County _____ State _____ Zip _____ Phone(_____) _____	Human exposure? Yes / No _____ Exposed _____ Address _____ City _____ County _____ State _____ Zip _____ Phone (_____) _____	Type of exposure? _____ Physician _____ Address _____ City _____ County _____ State _____ Zip _____ Phone (_____) _____
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