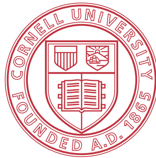
General Submission Form



Animal Health Diagnostic Center

College of Veterinary Medicine, Cornell University
In Partnership with the NYS Dept of Ag & Markets

US Postal Service Address:
PO Box 5786
Ithaca, NY 14852-5786

Courier Service Address:
Upper Tower Rd
Ithaca, NY 14853

AHDC Contacts
Phone: 607-253-3900
Fax: 607-253-3943
Web: diagcenter.vet.cornell.edu
E-mail: diagcenter@cornell.edu

LAB USE ONLY

AHDC Accession No./ Date ______

Pathology Case Number (if any) ______

PLEASE COMPLETE ALL FIELDS, PRINT LEGIBLY, AND ENTER ONLY ONE OWNER PER FORM

Enter Your Cornell AHDC Acct No. ______

Your Internal Case/Reference No.** ______

Submitting Veterinarian* ______

Clinic Name ______

Address ______

City, State, Zip ______

Phone No. (______) ______ Fax No. (______) ______

Submitting Vet's Signature: ______

Owner ______

Address ______

City, State, Zip ______

Phone Number (______) ______

County ______ Town ______

NYS Premises ID ______

Add'l instructions:

ATTENTION:

☐ Check here for test results to be **faxed**; otherwise, they will be mailed.

Testing purpose, if not clinical: ______

☐ **Export** Country of Destination ______

☐ **Regulatory** Shipper/Exporter ______

Clinical / Differential Diagnosis: ______

______ PLEASE PROVIDE HISTORY

Enter previous related *Accession Numbers* with *Dates*: ______

Check if related material has been submitted previously **for this animal(s):** ☐ Y ☐ N ☐ Unknown ______

for this herd: ☐ Y ☐ N ☐ Unknown ______

HISTORY: To qualify for NY State Contract pricing (see the AHDC Test & Fee Schedule), a detailed history ***must*** be provided.

Date of onset of Herd illness: ______

In animals submitted: ______

☐ Check here if history is continued on back of this page, or if add'l history is attached.

Herd size: ______

No. dead: ______

No. affected: ______

ANIMAL IDENTIFICATION

SEX CODES: M=Male, MR=Mare (equine only), MC=Castrated Male, F=Female, SF=Spayed Female
AGE CODES: Y=Years, M=Months, W=Weeks, D=Days; DOB=Date of Birth

NO.	NAME / IDENTIFIER NO.	SPECIES	BREED	SEX	AGE/DOB	**SPECIMEN SUBMITTED** PLEASE INDICATE SAMPLING SITE	**DATE TAKEN**	**TEST(S) REQUESTED** (per animal) PLEASE ENTER FULL NAME OF TEST
1								
2								
3								
4								
5								
6								
7								
8								
9								

Comments:

☐ *List add'l items on 2nd page*

PLEASE NOTE: SAMPLES SUBMITTED FOR TESTING BECOME THE PROPERTY OF THE ANIMAL HEALTH DIAGNOSTIC CENTER.

* The submitting veterinarian is responsible for the requested tests, fees associated with this submission, and to notify the owner of test results.

Page ___ of ___

AHDC USE ONLY
OPENED BY: ______

☐ DHL ☐ FX ☐ UPS-Grnd ☐ UPS-ND

☐ Mail ☐ Pri Mail ☐ Exp Mail ☐ Other: ______

DATE/TIME REC'D: ______

SHIPPED: ______

☐ FROZEN ☐ NOT FROZEN ☐ NONE ☐ COMMENT: ______

☐ DRY ICE ☐ COLD PACK

☐ RM TEMP ☐ COOL ☐ COLD

** If your Internal Reference No. is entered on this form, it will be used to identify this case on the test result form and on the billing statement (max. 17 character field).