VENEREAL AGENTS SUBMISSION FORM

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LABEL

* Required field

OWNER* _____
Farm _____
Address* _____
City* _____
State* _____ Zip _____
Premise ID _____

Date collected* _____
Date samples shipped* _____
Number Submitted _____
Species _____

Reason for Test _____

VETERINARIAN* _____
License No.* _____
Clinic* _____
Clinic Acct.# _____
Address* _____
City* _____ State* ____ Zip _____
Clinic Premise ID _____
E-mail _____
Phone* _____ **FAX*** _____

Tests Requested

Trichomonas*: ☐ Culture ☐ Direct Exam ☐ PCR^

Campylobacter ☐ * Two separate trich samples (submitted in In-Pouch media) are needed if requesting BOTH culture & PCR.

^A loss of sensitivity (up to 6 CTs) may occur when using/submitting tubes instead of pouches for Trich PCR assay.

Sample #	Animal Identification	Trichomonas*			Campylobacter
		Culture	Direct	PCR^	
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					
17.					
18.					
19.					
20.					

Submitting Veterinarian's Signature* _____
(Signature indicates that specimen(s) were collected by or under the supervision of the signing veterinarian.)