



Shipping Address: Carthage Diagnostic Laboratory
980B Center Street
Carthage, IL 62321

Phone: (217) 357-8304
Fax: (877) 828-2608

OWNER
 Veterinarian _____
 Address _____
 City, State, Zip _____

Affiliates (list codes)

Reporting Requests

Phone _____
 Fax _____
 Email _____

Species: Porcine **Referring Clinic:** _____

ANIMAL LOCATION	
Premises, Herd, Submission-Level Identifiers:	
SITE NAME _____	
Address _____	
City, State, Zip _____	
County _____	
Premises ID # _____	Premises Type: _____
Reference (Other) _____	
Lot or Group ID _____	
Source of Flow ID _____	

SAMPLES

Collection Date _____ **No. of Samples** _____

Consecutively numbering samples (e.g. 1, 2, 3, 4,) greatly enhances receiving, accessioning, and sample processing efficiencies within the laboratory.

Sample ID #	Animal ID	Age (check unit)				Location (other)	Sex	Weight (lb.)
		<input type="checkbox"/> d	<input type="checkbox"/> wk	<input type="checkbox"/> mo	<input type="checkbox"/> yr			
1								
2								
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4								
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27								
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29								
30								

SAMPLE TYPE	Serum	Oral Fluids	Blood Swab	Nasal Swab	Feces	Fecal Swabs	Environmental	Other
CONSECUTIVE SAMPLE ID#'S	___ to ___	___ to ___	___ to ___	___ to ___	___ to ___	___ to ___	___ to ___	___ to ___

***All samples will be tested for each assay requested unless noted in the column "Test Sample #'s"**

<p>Serology</p> <p style="text-align: right; margin-right: 50px;">Test Sample #'s</p> <p><input type="checkbox"/> M. hyopneumoniae ELISA _____</p> <p><input type="checkbox"/> PRRS ELISA _____</p>	<p>Bacteriology</p> <p style="text-align: right; margin-right: 50px;">Test Sample #'s</p> <p><input type="checkbox"/> Bacterial Isolation _____</p> <p><input type="checkbox"/> Isolate Growth confirmation _____</p> <p>Expected Organism(s) _____</p>
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Molecular

* *Samples tested individually, unless otherwise indicated.*

Pool all samples in groups of _____ (≤ 5)

PCR	Test Sample #'s	Test Individually	Pool (≤5)	Test Positive Pool Individually
<input type="checkbox"/> IAV Screen	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> M. hyopneumoniae	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> PED/PDCoV/TGE	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> PRRS (NA / EU)	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Additional Information or Test Requests: