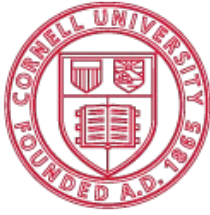


Submission Form: Shar-Pei Autoinflammatory Disease (SPAID)



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
FEDEX/UPS Address: 240 Farrier Rd
Ithaca, NY 14853

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

LAB USE ONLY

AHDC Accession No./Date

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

*Results will be sent to the owner listed below.

The veterinarian's or licensed veterinary technician's information is required. Permanent ID must be verified by the licensed professional taking and submitting the sample at the time the sample is drawn.

Owner's name _____	Veterinarian Account number _____
Co-owner's name _____	Clinic/Vet Name _____
Mailing Address _____	Clinic/Vet Mailing Address _____
City, State _____	Clinic/Vet City, State _____
Zip/Postal Code _____	Clinic/Vet Zip/Postal Code _____
Country _____	Clinic/Vet Country _____
Phone _____	Clinic/Vet Phone _____
Fax _____	Clinic/Vet Email _____
Email _____	

Please indicate how results should be returned: Fax Email Postal Service

Dog Information

Breed **SHAR-PEI** Sex M F Color/Markings _____

Call Name _____ Date of Birth _____ (MM/DD/YY)

Registered Name _____ N/A

Registration Number (AKC or other) _____ N/A

Microchip/Tattoo Number (required) _____ Microchip Tattoo

Registered Name of Sire _____

Registered Name of Dam _____

Registration Number of Sire _____ Registration Number of Dam _____

I certify that the sample submitted is from the dog described above and that all the information provided is accurate, to the best of my knowledge, including permanent identification (microchip or tattoo).

Licensed Professional; _____ Date _____

Please complete the attached Shar-Pei Health Form

Payment Must Accompany Sample(s), Please Submit a Credit Card Authorization Form

Samples will not be tested until payment is authorized.

(Add totals for each dog/form and enter as payment total on credit card authorization form.)	Test fee	\$ 180.00
	Accessioning Fee (per sample)	\$ 5.00
	Total	\$185.00

Payment Total: _____

Note: Fees for reporting to outside agencies require use of specific agency forms and instructions.



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Shar-Pei Autoinflammatory Disease (SPAID)

Information for the Submitting Veterinarian

Sampling

- Both the dog owner and the veterinarian/licensed veterinary technician should complete the form. The dog's identity should be verified at the time of sampling.
- The blood sample should be collected in two(2) 4ml EDTA tubes. Mark the samples with the dog's registration number and/or chip number. A minimum of 2 ml of blood is required. The EDTA tube containing the blood should be at least 1/2 full.
- The samples are sent to the address below by overnight carrier:

Animal Health Diagnostic Center

FedEx/UPS Address
240 Farrier Rd
Ithaca, NY 14853

US Postal Service Address
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Ithaca, NY 14852-5786



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HEALTH FORM SHAR-PEI (SPAID)

GENERAL QUESTIONS

Owner:

Dog's registered name:

Dog's call name:

Reg. Number:

Date of birth:

Dog's weight at time of sampling:

Date blood obtained:

Sex: Male Female **Castrated:** No Yes **Date/Year:**

Coat color:

- | | | | |
|-------------------------------------|-----------|--|-----------------|
| <input type="checkbox"/> Red | Black | <input type="checkbox"/> Blue | Cream Pigmented |
| <input type="checkbox"/> Red Fawn | Chocolate | <input type="checkbox"/> Blue Dilute | Cream Dilute |
| <input type="checkbox"/> Fawn | Brown | <input type="checkbox"/> Isabella | Apricot Dilute |
| <input type="checkbox"/> Red Dilute | Lilac | <input type="checkbox"/> Isabella Dilute | Other |

Coat type: Brushcoat Horsecoat Bearcoat

Shar-Pei Type: Meatmouth Bonemouth

Check the box above the dog who looks most like yours:

A B C D



Is the dog's veterinary record included?: No Yes

Is an image of the dog included?: No Yes

HAS YOUR DOG SUFFERED ANY OF THE FOLLOWING HEALTH ISSUES?

1. FEVER No Yes

If "Yes", How old was the dog when the first event occurred?

How many fever events have there been since?

If frequent, how often are the events (monthly, weekly, other)?

Does the dog have swelling with the fever? No Yes

If "Yes" where, hocks muzzle other?

How high is the fever? 103°F/39.5°C 104°F/40 °C 105°F/40.5 °C 106°F/41 °C

Approximately, for how many hours did the fever last?

Have fever events ever occurred shortly after vaccinations or were they associated with any specific environmental trigger? If yes, please describe.

Is this dog on colchicine or any other anti-inflammatory medication or supplements? If yes, please describe including dosage, frequency and duration. Alternatively, please include vet records.

2. INFLAMMATION

Has the dog had joint swelling (including swollen hocks) without apparent fever? No Yes

Does the dog occasionally seem reluctant/unwilling to move, or behave differently as though not feeling well or in pain? Please describe.

Have there been any unusual or abnormal laboratory test results or disease symptoms that might suggest chronic inflammation? No Yes – Please describe

Have the dog's cobalamin levels been measured? No Yes

If yes, was the dog deficient? What was the value?

3. AMYLOIDOSIS

Has the dog been diagnosed with amyloidosis as confirmed by biopsy? No Yes

Have there been signs of kidney and/or liver problems through blood/urine testing? No Yes

Please describe, or indicate if we may contact your veterinarian for more details? No Yes

4. RELATIVES

Does this dog have relatives that you know of that have had fever events and/or swollen hocks?

No Yes, Indicate relationship:

Does the dog have any relatives that have died of confirmed amyloidosis or kidney/liver failure suggestive of amyloidosis? No Yes

Please indicate relationship and if the result was confirmed by biopsy or post-mortem.

Has this dog produced offspring with Fever Swollen hocks Amyloidosis

Please indicate relationship:

5. OTHER HEALTH ISSUES

Has the dog been diagnosed with any of the following issues?

- | | |
|--|---|
| <input type="checkbox"/> Cutaneous mucinosis | <input type="checkbox"/> Entropion |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Other skin/ear problems |
| <input type="checkbox"/> Luxating patella/s | <input type="checkbox"/> Lens luxation (PLL) |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Lymphangitis or lymphedema |
| <input type="checkbox"/> Cancer (which type?) | <input type="checkbox"/> Mast cell disease |
| <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Inflammatory bowel disease |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Seizures or other neurological issue |
| <input type="checkbox"/> Vasculitis, STSS or similar skin slough | |
| <input type="checkbox"/> Other? | |

PLEASE STATE CONTACT INFORMATION:

Owner address:

Telephone Number:

Email :

Clinic/Vet Name:

Telephone Number:

Email :

Other comments:

I, _____, agree to share my dog's pedigree information and make my dog's DNA sample available for further research related to discovery of genetic components to heritable diseases in the Shar-Pei breed.

Signature: _____

Thanks for your effort!

Please submit this health form along with the sample submission form and blood samples.