



Cytology 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: FedEx/UPS Service
PO Box 5786 Address: 240 Farrier Rd.
Ithaca, NY 14852-5786 Ithaca, NY 14853

AHDC Contacts
Phone: 607-253-3900
Fax: 607-253-3943
Web: ahdcenter@cornell.edu
Email: diagcenter@cornell.edu

LAB USE ONLY

AHDC Accession No. / Date

PLEASE NOTE: SAMPLES SUBMITTED FOR TESTING
BECOME THE PROPERTY OF THE ANIMAL HEALTH
DIAGNOSTIC CENTER AND MAY BE TESTED AS
PART OF STATE/FEDERAL SURVEILLANCE PROGRAMS

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

Check if STAT needed (Fee + add'l \$45) Available Monday through Friday.

AHDC Acct. No. _____	Your Internal Case / Reference No. ** _____
Submitting Veterinarian* _____	Owner _____
Clinic Name _____	Address _____
Address _____	City, State, Zip _____
City, State, Zip _____	Phone No. (____) _____
Phone No. (____) _____ Fax No. (____) _____	County _____ Town _____
Submitting Vet's Signature: _____	NYS Premises ID _____

ANIMAL IDENTIFICATION (only one animal per form):
SEX Codes: M=Male, MR=Mare(Equine only), MC=Castrated Male, F=Female, SF=Spayed Female
AGE CODE: Y=Years, M=Months, W=Weeks, D=Days, DOB=Date of Birth

Name/Identifier No.	Species	Breed	Sex	Age/DOB	Sampling Date

CYTOLOGY TESTS REQUESTED : Please check all that apply:

<input type="checkbox"/> Cytology Smear Exam(s): Sources: _____	<input type="checkbox"/> Peritoneal Fluid	<input type="checkbox"/> Smears Submitted
_____	<input type="checkbox"/> Pleural Fluid	<input type="checkbox"/>
_____	<input type="checkbox"/> Pericardial Fluid	<input type="checkbox"/>
_____	<input type="checkbox"/> BAL Smear Exam and Counts	<input type="checkbox"/>
_____	<input type="checkbox"/> BAL Smear Exam Only	<input type="checkbox"/>
<input type="checkbox"/> Bone Marrow: Site: _____	<input type="checkbox"/> Tracheal Wash	<input type="checkbox"/> TTW <input type="checkbox"/> Scope <input type="checkbox"/>
<input type="checkbox"/> Synovial Fluid: Site(s): _____	<input type="checkbox"/> Cerebrospinal Fluid	<input type="checkbox"/> AO <input type="checkbox"/> LS <input type="checkbox"/>

HISTORY/CLINICAL INFORMATION:

Clinical / Differential Diagnosis: _____
Has related material been submitted previously for this animal: Y N Accession No. _____

Clinical Summary (imaging findings, appearance, size and lesion(s) distribution): <input type="checkbox"/> Check here if history is continued on back, or if add'l history is attached.	Other Diagnostic tests requested: (example; CBC, Chemistry Panel)	
	Specimen and Anatomical Site	Tests Requested (Enter full name of test)

AHDC USE ONLY	<input type="checkbox"/> FEDEX	<input type="checkbox"/> MAIL	DATE REC'D: _____	<input type="checkbox"/> FROZEN	<input type="checkbox"/> DRY ICE
OPENED BY: _____	<input type="checkbox"/> FEDEX-GRND	<input type="checkbox"/> PRI MAIL	TIME REC'D: _____	<input type="checkbox"/> RM TEMP	<input type="checkbox"/> COLD PACK
	<input type="checkbox"/> UPS-GRND	<input type="checkbox"/> EXP MAIL		<input type="checkbox"/> COOL	<input type="checkbox"/> NONE
	<input type="checkbox"/> UPS-ND	<input type="checkbox"/> OTHER: _____	DATE SHIPPED: _____	<input type="checkbox"/> COLD	<input type="checkbox"/> COMMENT: _____

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