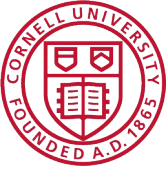


Submission Form: Genetic Test for Primary Hyperparathyroidism (PHPT)



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: vet.cornell.edu/ahdc
 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

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

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

Dog Information

Breed **KEESHOND** Sex _____ 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 _____

PHPT genetic test results may be reported to a third party such as the Orthopedic Foundation for Animals (OFA), if the owner so chooses and appropriate documents and payments for fees are included (www.offa.org). Please be assured that test results will not be forwarded to OFA or any other third party without written permission from the authorized submitter.

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).

Authorized Submitter _____ Date _____

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	\$ 135.00
	Accessioning Fee (per sample)	\$ <u>6.00</u>
	Total	\$ 141.00

Payment Total: _____

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