



OPERASI PERKHIDMATAN SOKONGAN

**FAKULTI PERUBATAN VETERINAR
(UNIT PERKHIDMATAN MAKMAL VETERINAR)**

Kod Dokumen: OPR/FPV/BR085/SSR

SPECIMEN SUBMISSION & REQUEST FORM

SPECIMEN SUBMISSION & REQUEST FORM						LAB USE ONLY	
						Lab. Ref. No	Received
							Date:
	Time :						
Patient/Specimen							
Case No:	Patient ID:	Species :	Age :	Previous Lab No. (Repeat)			
Owner :		Breed :	Sex :				
LABORATORY SERVICE(S) REQUESTED	Haematology & Clinical Biochemistry	Parasitology	Bacteriology	Pathology	Biologic/ HiCOE IBS	Virology	
Specimen (type) :							
Collection Method (if applicable)							
History/Findings/PM - (for biopsy specimen state : location, size, consistency, rate of growth & duration) :							
Tentative Diagnosis :				Date :			
				Time :			
Clinician/Submitter							
Name :				Address (if applicable) :			
Tel :							
H/P :				Fax :			
Signature (Clinician/Pathologist/Others)				Student Name: H/Phone:			
Charge to : <input type="checkbox"/> UVH <input type="checkbox"/> Lab <input type="checkbox"/> Client Research (Vot:)						Discount (%)	
						<input type="checkbox"/> Teaching <input type="checkbox"/> 30 <input type="checkbox"/> 50 <input type="checkbox"/> 100	
Please Fill in PAGE 2 to Request Specific Test(s)							

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Website : www.vet.upm.edu.my



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			Patient ID :	Time :																
PLEASE MARK (✓) THE TEST(S) REQUIRED																				
HAEMATOLOGY & CLINICAL BIOCHEMISTRY																				
<p>HAEMATOLOGY</p> <input type="checkbox"/> Complete Haemogram	<p>BIOCHEMISTRY</p> <input type="checkbox"/> Electrolytes (Na, K, Cl) <input type="checkbox"/> Calcium <input type="checkbox"/> Inorganic Phosphate <input type="checkbox"/> Urea <input type="checkbox"/> Creatinine <input type="checkbox"/> Glucose <input type="checkbox"/> Cholesterol <input type="checkbox"/> Bilirubin, Total <input type="checkbox"/> Bilirubin, Conjugated <input type="checkbox"/> ALT <input type="checkbox"/> AP (ALP) <input type="checkbox"/> GGT <input type="checkbox"/> Amylase <input type="checkbox"/> AST <input type="checkbox"/> CK (CPK), Total <input type="checkbox"/> LDH <input type="checkbox"/> Total Protein (Serum) <input type="checkbox"/> Albumin <input type="checkbox"/> Globulin <input type="checkbox"/> A:G <input type="checkbox"/> Triglyceride <input type="checkbox"/> Uric Acid <input type="checkbox"/> Lactate <input type="checkbox"/> Lipase <input type="checkbox"/> Others (Please Specify):	<p>URINALYSIS</p> <p>Sample:</p> <input type="checkbox"/> Spontaneous Micturition <input type="checkbox"/> Catheterisation <input type="checkbox"/> Cystocentesis <input type="checkbox"/> Manual Compression																		
<p><u>Individual Tests</u></p> <input type="checkbox"/> PCV & Plasma Protein <input type="checkbox"/> Reticulocytes <input type="checkbox"/> Fibrinogen				<input type="checkbox"/> General Examination (Physical, Chemical, Microscopic) <input type="checkbox"/> Specific Gravity (S.G.) <input type="checkbox"/> Dipstick Test <input type="checkbox"/> Bence Jones Protein																
<p>COAGULATION (Citrated Blood)</p> <input type="checkbox"/> APTT <input type="checkbox"/> PT <input type="checkbox"/> Fibrinogen				<p>CYTOLOGY</p> <input type="checkbox"/> FNA : <input type="checkbox"/> Fluid : <input type="checkbox"/> Impression Smear : <input type="checkbox"/> Wash : <input type="checkbox"/> CSF : <input type="checkbox"/> Others (Please Specify):																
<p>MISCELLANEOUS</p> <input type="checkbox"/> Crossmatching <input type="checkbox"/> Others (Please Specify):				<p>FAECAL EXAMINATION</p> <input type="checkbox"/> General Examination (Physical, Chemical, Microscopic) <input type="checkbox"/> Occult Blood <input type="checkbox"/> Trypsin <input type="checkbox"/> Others (Please Specify):																
PARASITOLOGY		PATHOLOGY																		
<input type="checkbox"/> Identification of Endo/Ectoparasites <input type="checkbox"/> Faecal Examination <ul style="list-style-type: none"> <input type="checkbox"/> Direct Smear (with/without staining) <input type="checkbox"/> Simple Floatation <input type="checkbox"/> Sedimentation <input type="checkbox"/> McMaster <input type="checkbox"/> Larva Culture <input type="checkbox"/> Blood Examination for Protozoa and/or Heartworm <input type="checkbox"/> Examination/Identification/Enumeration of parasites <input type="checkbox"/> Others (Please specify):		<input type="checkbox"/> Post-mortem Examination <input type="checkbox"/> Biopsy Examination <input type="checkbox"/> Others (Please Specify):																		
		BIOLOGIC/HICOE IBS																		
		<p>PCR</p> <input type="checkbox"/> IBDV <input type="checkbox"/> NDV <input type="checkbox"/> CAV <input type="checkbox"/> Avian Influenza Virus <input type="checkbox"/> Others (Please Specify):																		
BACTERIOLOGY		VIROLOGY																		
<input type="checkbox"/> Isolation & Identification: <input type="checkbox"/> Serology: <input type="checkbox"/> Others (Please Specify):		<input type="checkbox"/> Egg Inoculation <input type="checkbox"/> Cell Culture <input type="checkbox"/> Identification Test <input type="checkbox"/> Serological Test <input type="checkbox"/> Others (Please Specify):																		
<p>Sensitivity Test</p> <table border="0" style="width: 100%;"> <tr> <td><input type="checkbox"/> Amoxycillin</td> <td><input type="checkbox"/> Chloramphenicol</td> <td><input type="checkbox"/> Gentamycin</td> <td><input type="checkbox"/> Norfloxacin</td> </tr> <tr> <td><input type="checkbox"/> Amox/Clav</td> <td><input type="checkbox"/> Enrofloxacin</td> <td><input type="checkbox"/> Kanamycin</td> <td><input type="checkbox"/> Orbifloxacin</td> </tr> <tr> <td><input type="checkbox"/> Ampicillin</td> <td><input type="checkbox"/> Erythromycin</td> <td><input type="checkbox"/> Marbofloxacin</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Cephalexin</td> <td></td> <td><input type="checkbox"/> Neomycin</td> <td></td> </tr> </table>		<input type="checkbox"/> Amoxycillin	<input type="checkbox"/> Chloramphenicol	<input type="checkbox"/> Gentamycin	<input type="checkbox"/> Norfloxacin	<input type="checkbox"/> Amox/Clav	<input type="checkbox"/> Enrofloxacin	<input type="checkbox"/> Kanamycin	<input type="checkbox"/> Orbifloxacin	<input type="checkbox"/> Ampicillin	<input type="checkbox"/> Erythromycin	<input type="checkbox"/> Marbofloxacin		<input type="checkbox"/> Cephalexin		<input type="checkbox"/> Neomycin		<input type="checkbox"/> Penicillin G <input type="checkbox"/> Polymixin B <input type="checkbox"/> Streptomycin <input type="checkbox"/> Sulfazole/Trime <input type="checkbox"/> Tetracycline <input type="checkbox"/> Triple Sulpha		
<input type="checkbox"/> Amoxycillin	<input type="checkbox"/> Chloramphenicol	<input type="checkbox"/> Gentamycin	<input type="checkbox"/> Norfloxacin																	
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<input type="checkbox"/> Cephalexin		<input type="checkbox"/> Neomycin																		
<input type="checkbox"/> Others (Please Specify):																				
LAB. USE ONLY																				
<p>Y N</p> Appropriate Sample <input type="checkbox"/> <input type="checkbox"/> Competent Personnel <input type="checkbox"/> <input type="checkbox"/>	<p>Y N</p> Appropriate Test Method <input type="checkbox"/> <input type="checkbox"/> Resources <input type="checkbox"/> <input type="checkbox"/>	<p>Y N</p> Commencement of Work <input type="checkbox"/> <input type="checkbox"/> (If No, pls fill in OPR/FPV/BR086/ROC) Signature:																		