

Oklahoma Animal Disease Diagnostic Laboratory

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Stillwater, OK 74078
405-744-6623



US Mail:
PO BOX 7001
Stillwater, OK 74076
oaddl@okstate.edu

TRICHOMONIASIS PCR SUBMITTAL FORM

OWNER

CLINIC / DVM

Premise ID	County	Account #
Owner(s)		Clinic
Address		Veterinarian
City	State Zip	Address
Primary Phone #		City State Zip
Email		Primary Phone #
Alternate Contact		Email
Submitter / Bill Party: <input type="checkbox"/> Vet <input type="checkbox"/> Owner		Collection Date _____
Report To: <input type="checkbox"/> Vet <input type="checkbox"/> Owner		NOTE: Please send samples WITHIN 5 DAYS of collection. Samples over 7 days old and expired pouches cannot be tested for regulatory purposes.

SIGNATURE OF SUBMITTER / DATE:

PRINT NAME:

TESTING INFORMATION

Total Number of Samples Submitted: _____

Test Requested: Individual PCR (bulls from multiple owners must be tested individually)
 Pooled PCR, up to 5 animals, all pooling done at OADDL (sale barn samples cannot be pooled)
NOTE: Some states will not accept pooled samples. Check the state of destination for requirements.

Reason for test: General Diagnostics Movement, change of ownership or lease Retest

InPouch Incubation prior to submission at 37°C None 24 hrs 48 hrs other _____

#	OFFICIAL IDENTIFICATION NUMBER	AGE	BREED	SEX	ADDITIONAL INFORMATION
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					

LAB USE ONLY Comments: _____

<p>RECEIPT RECORD</p> <input type="checkbox"/> UPS <input type="checkbox"/> Vet <input type="checkbox"/> Mail-post mark _____ <input type="checkbox"/> FedEx <input type="checkbox"/> Owner <input type="checkbox"/> Postage Due _____ <input type="checkbox"/> Courier <input type="checkbox"/> Other <input type="checkbox"/> Incubator login (date/time) _____	<p>CONDITION UPON RECEIPT</p> <input type="checkbox"/> Good <input type="checkbox"/> Leaked <input type="checkbox"/> No refrigeration <input type="checkbox"/> Cold Pack Other _____	<p>SAMPLE RECEIVED</p> <p>Opened by: _____</p>
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