

ADD ON REQUEST FORM VETERINARY

ORDERING FACILITY INFORMATION			
Requesting Facility		Facility Contact	
Requesting Facility Fax Number		Date of Add-on Request	

Add-on Information - to be completed by ordering facility employee	
Add-on Test Requested	
Add-on Accession Number	

Specimen Information - to be completed by MVD employee			
Original Test Requested	<input type="checkbox"/> Histo Ag. <input type="checkbox"/> Blasto Ag. <input type="checkbox"/> Cocci Ag. <input type="checkbox"/> Asper Ag. <input type="checkbox"/> Fungitell <input type="checkbox"/> Crypto Ag. <input type="checkbox"/> Cocci FID <input type="checkbox"/> Asper FID <input type="checkbox"/> Itraconazole by BioAssay <input type="checkbox"/> Histo Canine Ab IgG <input type="checkbox"/> Histo Feline Ab IgG <input type="checkbox"/> Cocci Canine Ab IgG <input type="checkbox"/> Blasto Canine Ab IgG		
Original Test Date at MVD			
Patient Last Name		Patient First Name	
Original Accession Number		Collection Date	
Specimen Type	<input type="checkbox"/> Urine <input type="checkbox"/> Serum <input type="checkbox"/> CSF <input type="checkbox"/> BAL <input type="checkbox"/> Other: _____		

Specimen Volume Check - to be completed by MVD Clinical Laboratory Employee			
Volume available for testing: _____ uL/mL	<input type="checkbox"/> Acceptable	<input type="checkbox"/> QNS	Initials
Specimen stability check: <input type="checkbox"/> Acceptable <input type="checkbox"/> Unable to Test <input type="checkbox"/> Suboptimal (*See below)			Initials
*If specimen is Suboptimal	Proceed with test per _____ Please note: For specimens originating from the state of New York, the person authorizing suboptimal testing must also sign this form.		

Client Signature: By signing below, I am stating that all of the above information has been reviewed and is correct.		
Name	Signature	Date

PLEASE FAX COMPLETED FORM BACK TO 317-455-2156