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: ahdc.vet.cornell.edu
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

*****Results will be sent to the owner listed below, except when submitted under the account of a licensed veterinarian.
♦ **The veterinarian's information is required only for those samples submitted under the account of a licensed veterinarian**. It will be the veterinarian's responsibility to provide results to the owner in these instances.

* 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.)

Payment Total: _____

Test fee	$ 90.00
Accessioning Fee (per sample)	$ 2.00
Total	$92.00

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