



Ministry of
Agriculture
and Food

ANIMAL HEALTH CENTRE
BC Ministry of Agriculture and Food
 1767 Angus Campbell Rd.
 Abbotsford BC, V3G 2M3

www.gov.bc.ca/animalhealthcentre
 AAVLD—Accredited Laboratory
 604-556-3003 1-800-661-9903
 Fax: 604-556-3010
 Email: PAHB@gov.bc.ca

FOR LAB USE ONLY	ENTERED: _____	VERIFIED: _____	SENT: _____		
	DATE: _____	DATE: _____	PM <input type="checkbox"/> SER <input type="checkbox"/>	CASE #: _____	COORD: _____

*** Please ensure all required information (in red with *) is completed. Samples with incomplete forms will not be tested.**

CLIENT REFERENCE #:		COLLECTED ON: (YYYY/MM/DD)		SUBMITTED ON: (YYYY/MM/DD)	
<input type="checkbox"/> Insurance Claim <input type="checkbox"/> Possible Litigation <input type="checkbox"/> Rehab/Rescue		SUSPECT FAD/ZOONOTIC AGENT:			
* SUBMITTED BY: <input type="checkbox"/> Owner <input type="checkbox"/> Vet Clinic <input type="checkbox"/> Other (Fill out info →)		SUBMITTER AND/OR BILLING:		ACCOUNT #:	
* BILL TO: <input type="checkbox"/> Owner <input type="checkbox"/> Vet Clinic <input type="checkbox"/> Other (Fill out info →)		NAME:			
* REPORTS TO:† <input type="checkbox"/> Owner <input type="checkbox"/> Vet Clinic <input type="checkbox"/> Other (Fill out info →)		ADDRESS:			
† Reports will be sent by email (or fax) to each of the parties indicated above. Preliminary reports will be sent to Vet Clinic unless otherwise specified.		CITY:		PROVINCE:	
ADDITIONAL REPORT EMAIL:		POSTAL CODE:		PHONE:	
ADDITIONAL REPORT EMAIL:		EMAIL / FAX:			
* OWNER:		PREMISE ID:		VETERINARIAN:	
				ACCOUNT #:	
FARM NAME:		VET CLINIC:			
* ADDRESS:		ADDRESS:			
* CITY:		* PROVINCE:		CITY:	
				PROVINCE:	
* POSTAL CODE:		* PHONE:		POSTAL CODE:	
				PHONE:	
EMAIL / FAX:		EMAIL / FAX:			
* PHYSICAL LOCATION OF ANIMALS: <input type="checkbox"/> OWNER/FARM ADDRESS (AS ABOVE) <input type="checkbox"/> OTHER LOCATION (SPECIFY BELOW)					
ADDRESS:		CITY:		POSTAL CODE:	
* BREED:		* AGE:		<input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Y * SEX: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> M/N <input type="checkbox"/> F/S <input type="checkbox"/> UNKNOWN	
ANIMAL ID/NAME:		* CCIA TAG NO. (whole animal only):			
USE/TYPE OF ANIMAL (select one): <input type="checkbox"/> Dairy <input type="checkbox"/> Fibre <input type="checkbox"/> Meat <input type="checkbox"/> Pet <input type="checkbox"/> Other <input type="checkbox"/> Unknown					
TOTAL # OF ANIMALS IN GROUP (number only):		# SICK:		# DEAD:	
* EUTHANIZED: <input type="checkbox"/> N/A <input type="checkbox"/> NO <input type="checkbox"/> YES – SPECIFY METHOD:				DATE ANIMAL DIED: (YYYY/MM/DD)	
TREATMENTS:					
<input type="checkbox"/> Unknown <input type="checkbox"/> None <input type="checkbox"/> Antibiotics <input type="checkbox"/> Fluids <input type="checkbox"/> Anti-inflammatories <input type="checkbox"/> Other (Please specify in History section)					
VACCINATION STATUS: <input type="checkbox"/> Unknown <input type="checkbox"/> None <input type="checkbox"/> Vaccinated (Specify):					
REASON FOR SUBMISSION (select one): <input type="checkbox"/> Diagnostic Investigation <input type="checkbox"/> Monitoring/Surveillance <input type="checkbox"/> Certify/Export/Pre-transfer <input type="checkbox"/> Research/Special Project (if different than Ref.#): <input type="checkbox"/> Other (Specify):					
PRIMARY PROBLEM (select one): <input type="checkbox"/> Death/Mortality/Moribund <input type="checkbox"/> General Illness <input type="checkbox"/> Poor Production <input type="checkbox"/> Decreased food/Water intake <input type="checkbox"/> Abortion <input type="checkbox"/> Gastroenteric/Diarrhea <input type="checkbox"/> Musculoskeletal <input type="checkbox"/> Neoplasia <input type="checkbox"/> Neurologic <input type="checkbox"/> Reproductive <input type="checkbox"/> Respiratory <input type="checkbox"/> Urinary <input type="checkbox"/> Other (Please specify in History section)					
SAMPLE SOURCE (select one): <input type="checkbox"/> Individual <input type="checkbox"/> Multi-individual <input type="checkbox"/> Pooled <input type="checkbox"/> Environmental <input type="checkbox"/> Other					
HISTORY: Describe clinical signs, date of onset, housing, production level, treatments given, ration type/diet, etc. Please ensure any written testing requests are at the top of this field.					
CONDITION SUSPECTED:		RELATED PREVIOUS AHC CASE #(s):			

* Please ensure all required information (in red with *) is completed. Samples with incomplete forms will not be tested.

HISTORY (Continued):

*** SPECIMENS SUBMITTED AND SERVICES REQUESTED** For 10 or more samples email a digital spreadsheet to: PAHB@gov.bc.ca

- Full Necropsy** *Includes up to 5 ancillary tests as deemed appropriate by the pathologist*
- Diagnostic Package** *On tissues collected outside of the AHC, includes up to 5 ancillary tests as deemed appropriate by the pathologist*
- Neurologic Examination** *Add spinal cord exam to necropsy (additional fees apply) – brain is included in standard necropsy **at pathologist's discretion***
- Include additional tests at pathologist's discretion** (additional fees may apply)

Serology	Parasitology	* Samples	* Sent #	Received # <small>Lab Use Only</small>			
<input type="checkbox"/> Johne's – Mycobacterium paratuberculosis <i>ELISA</i> <input type="checkbox"/> CAE – Caprine Arthritis Encephalitis <i>ELISA</i> <input type="checkbox"/> OPP – Ovine Progressive Pneumonia <i>ELISA</i> <input type="checkbox"/> CL – Caseous Lymphadenitis <i>ELISA</i> <input type="checkbox"/> C. Diff – Clostridium difficile toxin A&B <i>ELISA</i> <input type="checkbox"/> Q fever – Coxiella burnetti <i>ELISA</i> <input type="checkbox"/> Other Sero:	<input type="checkbox"/> Fecal Floatation <input type="checkbox"/> Modified McMaster's (<i>Fecal Egg Count</i>) <input type="checkbox"/> Baermann (<i>Lungworm</i>) <input type="checkbox"/> Strongyle Parasite Panel (<i>Float +/- McMaster's</i>) <hr/> Histopathology <input type="checkbox"/> Histopathology <input type="checkbox"/> IHC: <input type="checkbox"/> Other Histo:	Whole Animal					
		Fetus					
		Fixed Tissues					
		Fresh Tissues					
		Whole Blood					
		Serum					
		Feces					
		Urine					
		Milk					
		Viral Media Swab					
Bacteriology <input type="checkbox"/> Aerobic culture and sensitivity <input type="checkbox"/> Aerobic culture only <input type="checkbox"/> Anaerobic culture only (<i>includes C. perfringens detection</i>) <input type="checkbox"/> Clostridial FAT (<i>includes anaerobic culture</i>) <input type="checkbox"/> Clostridium perfringens toxin typing <input type="checkbox"/> Cryptosporidium spp. (<i>direct smear</i>) <input type="checkbox"/> Escherichia coli toxin typing <input type="checkbox"/> Fungal culture only <input type="checkbox"/> Listeria monocytogenes isolation <input type="checkbox"/> Milk culture and sensitivity <input type="checkbox"/> Salmonella culture <input type="checkbox"/> Other Bacti:	Virology: (<i>for full list of available isolation tests see fee guide</i>) <input type="checkbox"/> Virus Isolation for: <input type="checkbox"/> Electron Microscopy for: <input type="checkbox"/> Other Viro:	Bacti Media Swab					
		Dry Swab					
		Other (<i>list below</i>):					
		Check off tissue types below					
		<table style="width: 100%; border: none;"> <tr> <th style="width: 50%; border: none;">Fresh</th> <th style="width: 50%; border: none;">Formalized</th> </tr> </table>		Fresh	Formalized		
		Fresh	Formalized				
		<input type="checkbox"/> Brain	<input type="checkbox"/> Brain				
		<input type="checkbox"/> Heart	<input type="checkbox"/> Heart				
		<input type="checkbox"/> Lung	<input type="checkbox"/> Lung				
<input type="checkbox"/> Liver	<input type="checkbox"/> Liver						
<input type="checkbox"/> Kidney	<input type="checkbox"/> Kidney						
<input type="checkbox"/> Spleen	<input type="checkbox"/> Spleen						
<input type="checkbox"/> Stomach	<input type="checkbox"/> Stomach						
<input type="checkbox"/> Intestine	<input type="checkbox"/> Intestine						
<input type="checkbox"/> Muscle	<input type="checkbox"/> Muscle						
<input type="checkbox"/> Placenta	<input type="checkbox"/> Placenta						
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:						

Other testing requests and/or special instructions, and/or additional history:

Please view our full list of tests available in our fee guide at www.gov.bc.ca/animalhealthcentre

If you have questions regarding testing or type of samples to submit, please call 604-556-3003 or email PAHB@gov.bc.ca

*** IMPORTANT PLEASE READ:** By signing this form, the submitter acknowledges and agrees: 1) Specimens submitted are cremated on site following testing and ashes will not be returned. 2) Personal information supplied by the submitter is collected by His Majesty The King in right of B.C. as represented by the Minister of Agriculture and Food (AF) under s. 26(c) of the Freedom of Information and Protection of Privacy Act, for completing the requested testing and analysis. Such personal information will be used and disclosed only in accordance with that Act and the Animal Health Act. The submitter can direct any questions on personal information to PAHB@gov.bc.ca. 3) AF may use information related to food-producing animal testing for the summarized statistical surveillance of production animal health in B.C. 4) In the event of a suspected reportable, notifiable or foreign animal disease, the AHC must comply with relevant laws by confirming the diagnosis and notifying the appropriate agencies. 5) The AHC may send the specimen submitted to an external third-party laboratory for required testing at the discretion of the Case Coordinator, unless otherwise directed by the client.

*Submitter's Signature: _____ Date: (YYYY/MM/DD) _____