

SAMPLE SUBMISSION & TEST REQUEST FORM

LABORATORY USE ONLY		Lab. Ref. No	Received	
			Date:	Time:
<b>Sample</b>				
Case No:	ID:	Species:	Age:	Previous Lab No. (Repeat)
Owner:		Breed:	Sex:	
LABORATORY SERVICE(S) REQUESTED	Toxicity		Histology	
Sample (type):		URGENT:		<b>Sample Collection</b>
Collection Method (if applicable):		<input type="checkbox"/> YES		Date:
		<input type="checkbox"/> NO		Time:
<b>History and Findings</b> - (location, size, consistency, rate of growth, duration, etc):				
<b>Tentative Diagnosis:</b>				
<b>Submitter</b>				
I, hereby agree and will be responsible to pay charges for the services rendered by TuAH lab			Address (if applicable):	
Name :			Student Name:	
IC No. :				
Tel :			Tel:	
Email :			Email:	
Signature (-)				
Payment Method: <input type="checkbox"/> UVH <input type="checkbox"/> LO/PO <input type="checkbox"/> Online Transfer <input type="checkbox"/> Invoice <input type="checkbox"/> Research Vot:				
<b>Please Fill in PAGE 2 to Request Specific Test(s)</b>				

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Case No.	Sample ID	Lab. Ref. No	Date	Time			
<b>PLEASE MARK (✓) THE TEST(S) REQUIRED</b>							
<b>Toxicity &amp; Histology</b>		<b>Analytical Testing</b>					
<p><b>Oral toxicity</b></p> <input type="checkbox"/> Acute Oral Toxicity Study <input type="checkbox"/> Repeated Dose 28-Day Oral Toxicity Study <input type="checkbox"/> Repeated Dose 90-Day Oral Toxicity Study <input type="checkbox"/> <i>Others please specify</i> <p><b>Dermal toxicity</b></p> <input type="checkbox"/> Acute Dermal Toxicity Study <input type="checkbox"/> Repeated Dose 28-Day Dermal Toxicity Study <input type="checkbox"/> Repeated Dose 90-Day Dermal Toxicity Study <input type="checkbox"/> <i>Others please specify</i> <p><b>Histology</b></p> <input type="checkbox"/> Tissue Processing <input type="checkbox"/> Slide Preparation <input type="checkbox"/> "Hematoxylin and Eosin" Staining <input type="checkbox"/> Biopsy Examination <input type="checkbox"/> <i>Others please specify</i>		<input type="checkbox"/> Gas Chromatography/Mass Spectrometry <input type="checkbox"/> High-Performance Liquid Chromatography					
<b>Bacteriology</b>							
<input type="checkbox"/> Isolation of Lab Strain Bacteria ( <i>Streptococcus aureus, Pseudomonas aeruginosa, Bacillus subtilis, Escherichia coli</i> ) <input type="checkbox"/> Identification of Bacteria ( <i>Streptococcus aureus, Pseudomonas aeruginosa, Bacillus subtilis, Escherichia coli</i> ) <input type="checkbox"/> Antimicrobial Testing (Zone of Inhibition, Minimal Inhibitory Concentration (MIC), Minimal Bactericidal Concentration (MBC)) <input type="checkbox"/> <i>Others (Please Specify):</i>							
<b>Antibiotic Susceptibility Test:</b>							
<table style="width: 100%; border: none;"> <tr> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Ampicillin  <input type="checkbox"/> Cephalixin  <input type="checkbox"/> Cyproheptadine  <input type="checkbox"/> Enrofloxacin  <input type="checkbox"/> Erythromycin                             </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Gentamycin  <input type="checkbox"/> Kanamycin  <input type="checkbox"/> Neomycin  <input type="checkbox"/> Norfloxacin  <input type="checkbox"/> Doxycycline  <input type="checkbox"/> Penicillin G  <input type="checkbox"/> Polymixin B                             </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Streptomycin  <input type="checkbox"/> Sulfazole/Trime  <input type="checkbox"/> Tetracycline  <input type="checkbox"/> Cefovecin  <input type="checkbox"/> <i>Others (Please Specify):</i> </td> </tr> </table>					<input type="checkbox"/> Ampicillin <input type="checkbox"/> Cephalixin <input type="checkbox"/> Cyproheptadine <input type="checkbox"/> Enrofloxacin <input type="checkbox"/> Erythromycin	<input type="checkbox"/> Gentamycin <input type="checkbox"/> Kanamycin <input type="checkbox"/> Neomycin <input type="checkbox"/> Norfloxacin <input type="checkbox"/> Doxycycline <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"/> Cefovecin <input type="checkbox"/> <i>Others (Please Specify):</i>
<input type="checkbox"/> Ampicillin <input type="checkbox"/> Cephalixin <input type="checkbox"/> Cyproheptadine <input type="checkbox"/> Enrofloxacin <input type="checkbox"/> Erythromycin	<input type="checkbox"/> Gentamycin <input type="checkbox"/> Kanamycin <input type="checkbox"/> Neomycin <input type="checkbox"/> Norfloxacin <input type="checkbox"/> Doxycycline <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"/> Cefovecin <input type="checkbox"/> <i>Others (Please Specify):</i>					
<b>In-Vitro Bioassays</b>							
<input type="checkbox"/> Phytochemical Quantification (Total Phenolic Content, Total Flavonoid Content, Total Chlorophyll Content) <input type="checkbox"/> Antioxidant Assays (DPPH and FRAP assay) <input type="checkbox"/> Enzymatic Inhibition Assays (Alpha-Amylase, Alpha-Glucosidase, Acetylcholinesterase) <input type="checkbox"/> Anti-Cholesterol Assay							
<b>LAB. USE ONLY</b>							
Appropriate Sample	Y N	Appropriate Test Method	Y N	Commencement of Work			
Competent Personnel	□□	Resources	□□	□□			
Comment (if no):			Signature:				

