



Clinic Name: _____

Contact Name: _____

Email or fax number: _____

Oakdale
1163 Helmo Ave N
Oakdale, MN 55128
p: (651) 501-3766
f: (651) 501-3763

St. Paul
1542 W. 7th St
St. Paul, MN 55102
p: (651) 293-1800
f: (651) 291-1337

Sample Submission:

- Label tube with patient's name and last name
- Place tube in Ziploc bag
- Label Ziploc bag with patient's name, last name, species, and clinic
- Attach this order form to Ziploc bag

Patient Name: _____

Patient Species, Breed, Sex, & Birthdate: _____

Client First & Last Name: _____

Sample Drawn Date/Time: _____

Test Choice – please check the applicable box:

- | | |
|--|--|
| ☐ Automated CBC (Procyte Only) | ☐ Full CBC with Morphology |
| ☐ General Chemistry Profile w/Electrolytes | ☐ PT/aPTT Clotting Time (2ml Blue Top Tube (Citrate)) |
| ☐ SNAP Test, specify _____
(Parvo, Giardia, Lepto, 4DX, FeLV/FIV/HW, proBNP) | ☐ Ionized Calcium (1ml Green Top Tube) |
| ☐ Catalyst Cortisol test | ☐ Catalyst PL test (Pancreatic Lipase) |
| ☐ Other (Description) _____ | |

***Please Note: all lab tests listed above have a turnaround time within 2 hours, except the full CBC which is within 10 hours. If rush service is needed, please call in advance.**

***Please call and ask to speak with the lab technician if you have questions regarding availability of tests and sample requirements.**

AERC Staff Use Only

Patient ID _____ Date/Time sample was received _____

_____ Received form and sample

_____ Sent summary to rDVM

_____ Ran diagnostic test

_____ Attached completed form to clinical record

_____ Placed sample in fridge (if applicable)

Updated 3/30/2022