



PARASITOLOGY Laboratory Submission Form

Parasitology Laboratory VMC 0050
 601 Vernon L. Tharp Street, Columbus, OH 43210
 Phone: 614-292-8328
 Email: VMC.ParasitologyLab@osu.edu

Veterinarian: _____
 Clinic/Hospital: _____
 Address: _____
 Email: _____
 Phone: _____
 Signature: _____
 (circle preferred contact method)

Owner (Last, First): _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Email: _____

Name/Identifier #: _____

Species: Canine Feline Equine Bovine Ovine Caprine Camelid Avian Other: _____

Breed: _____ Age: _____ Sex: Male Female Male/Castrated Female/Spayed Unknown

Complaint: _____

Symptoms: _____

Duration: _____

Sample type: Serum Plasma Feces Skin Scraping Sputum CSF Other: _____
 Ectoparasite (indicate site of retrieval): _____

Sample collection date: _____

Particular parasite you suspect or wish to rule out: _____

Test requested: Centrifuge Flotation Sedimentation McMaster/Stoll's Cryptosporidium & Giardia Antigen
 Baermann Other (specify test): _____

Anti-parasite treatment history including date of last dose: _____

Travel history: _____

Previous occurrence(s): _____

Changes in the patient husbandry: _____

Contact with other animals and whether they are showing signs (indicate # exposed/total for herd): _____

Techniques performed to date: _____

Does the animal hunt, interact with, or have the opportunity to consume wildlife? Yes No Unknown