



<b>Molecular Biology Laboratory</b>	<b>AVIAN INFLUENZA TEST REQUEST FORM</b>	Filename: <b>MBL-MF-TESTREQUESTAIV</b>
Rev#: 03	Issue date: 3-DEC-25	Approved by: J. Smellie
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<b>Client's name and address</b>
<b>Address where animals are kept, if different from above</b>

<b>Requester details:</b>
Requester Name: _____
Requesting Organization: _____
Telephone number: _____
Email: _____
Signature: _____

<b>Species:</b>		
<input type="checkbox"/> Chicken	<input type="checkbox"/> Goose	<input type="checkbox"/> If other, please specify:
<input type="checkbox"/> Turkey	<input type="checkbox"/> Cattle	
<input type="checkbox"/> Duck	<input type="checkbox"/> Goat	

<b>Details:</b>		
<input type="checkbox"/> Breeder/parent - layers	<input type="checkbox"/> Broilers/Meat	<input type="checkbox"/> Wild
<input type="checkbox"/> Breeder/parent - Meat	<input type="checkbox"/> Captive/Zoo	<input type="checkbox"/> Pen/Barn
<input type="checkbox"/> Layers	<input type="checkbox"/> Pet/Backyard	<input type="checkbox"/> Free Range

<b>Clinical Signs:</b>		
<input type="checkbox"/> Wasting/poor condition	<input type="checkbox"/> Egg Drop	<input type="checkbox"/> Upper GIT signs
<input type="checkbox"/> Recumbent	<input type="checkbox"/> Egg Quality	<input type="checkbox"/> Vent/cloacal disorders
<input type="checkbox"/> Respiratory	<input type="checkbox"/> Abnormal faeces	<input type="checkbox"/> Lameness

<input type="checkbox"/> Musc/skel	<input type="checkbox"/> Found Dead	<input type="checkbox"/> Other:
<input type="checkbox"/> Nervous signs	<input type="checkbox"/> Unknown	
<input type="checkbox"/> Skin/Feather	<input type="checkbox"/> Healthy	

<b>Specimen Details:</b>		
<input type="checkbox"/> Pooled Sample	Indicate ( <b>Maximum 5</b> ):	
<input type="checkbox"/> Individual Sample		
<b>Sample type (only one in a pooled sample):</b>	<input type="checkbox"/> Oropharyngeal swab	
	<input type="checkbox"/> Cloacal swab	
	<input type="checkbox"/> Other:	

<b>Date of Collection:</b>	(dd/mm/yyyy)
<b>Time of Collection:</b>	(hr/mm)
<b>Total Number of Sample(s) sent:</b>	

<b>Detailed Clinical History:</b>		
<b>Date of Onset:</b>	(dd/month/yyyy)	
<b>Medical History:</b>		

<b>Examination(s) Requested:</b>
<input type="checkbox"/> CDC Influenza A H5/H7 Real-Time RT-PCR Panel

<b>LABORATORY USE ONLY -</b>			
<b>Date / Time Received:</b>		<b>Laboratory Specimen ID:</b>	
<b>Receiver Name:</b>		<b>Date of Testing:</b>	