

HYPERTROPHIC CARDIOMYOPATHY – VET FORM



Langford
VETERINARY SERVICES
Diagnostic Laboratories
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LAB USE ONLY

LAB No.....

Date Received.....

Microchip Checked(initials)

Hypertrophic Cardiomyopathy Genetic Mutation PCR Test

Section A (to be completed by the owner, or owner's agent)

*Owner's Name *Tel

*Address

*Post code

*Cat's full registered name

*Microchip No.

*Registration No *Registering body

*Breed Colour

Sex Date of birth

I declare that the cat presented for sampling is the cat described above, and that the particulars provided are correct.
I agree that the information obtained from the screening may be used for statistical research purposes which may be published.

*Date *Signed (Owner/Agent)

Section B (to be completed by the veterinary surgeon)

*Veterinary Surgeon Sample submitted:

*Practice Name EDTA Blood (minimum 0.5 ml)

*Practice Address OR

Buccal Swab

Date Collected

Time Collected

Telephone No Date Sent

Fax No

*I confirm that the sample submitted with this form was collected by me...YES / NO (delete as applicable)

*I have verified that the micro-chip number listed above is correct.....YES / NO (delete as applicable)

*Date *Signed F/MRCVS



For future inclusion on the FAB HCM Negative register :

- Fields marked * must all be completed
- The sample must be labelled with the cat's microchip number
- A copy of this submission form together with the test results for the cat will be required by FAB

Promotional code:

LVS Charges

Plus VAT