



Animal Diagnostic Laboratory  
Penn State University  
Orchard Road  
University Park, PA 16802  
Ph: 814-863-0837 Fax: 814-865-3907

Accession No.	_____
Data Entry	_____
Case Coordinator	_____
Date Submitted	_____
Case Tracking #	_____
Reference Lab	_____
<b>FOR LABORATORY USE ONLY</b>	

### MASTITIS MILK QUALITY SUBMISSION

**Owner/Company:**

Name \_\_\_\_\_  
 Business Name \_\_\_\_\_  
 Street \_\_\_\_\_  
 City, State \_\_\_\_\_  
 County \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone \_\_\_\_\_  
 Fax \_\_\_\_\_  
 Email \_\_\_\_\_

**Mail Diagnostic Report to:**

Owner       Vet/Agent  
 Submitter       Other

**FAX Diagnostic Report to:**

Owner       Vet/Agent  
 Submitter       Other

**Email Diagnostic Report to:**

Owner       Vet/Agent  
 Submitter       Other

**Bill Diagnostic Report to:**

Owner       Vet/Agent  
 Submitter       Other

**Specimen(s) Submitted:**

Date Obtained: \_\_\_\_\_

**Submitter/Service Person:**

Name \_\_\_\_\_  
 Business Name \_\_\_\_\_  
 Street \_\_\_\_\_  
 City, State \_\_\_\_\_  
 County \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone \_\_\_\_\_  
 Fax \_\_\_\_\_  
 Email \_\_\_\_\_

**Specimen Type(s)      No. of Specimens**

<input type="checkbox"/> Milk – Quarter	_____
<input type="checkbox"/> Milk - Composite	_____
<input type="checkbox"/> Bulk Tank	_____
<input type="checkbox"/> Referral Plate	_____
<input type="checkbox"/> Swab (Original)	_____
<input type="checkbox"/> Colostrum	_____
<input type="checkbox"/> Other	_____
<input type="checkbox"/> Other	_____

**Vet/Agent/Field Investigator:**

Name \_\_\_\_\_  
 Business Name \_\_\_\_\_  
 Street \_\_\_\_\_  
 City, State \_\_\_\_\_  
 County \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone \_\_\_\_\_  
 Fax \_\_\_\_\_  
 Email \_\_\_\_\_

Premise ID: \_\_\_\_\_

Dairy One?    Y    N

If Yes:

Center Name: \_\_\_\_\_

Herd Code: \_\_\_\_\_

**Other:**

Name \_\_\_\_\_  
 Business Name \_\_\_\_\_  
 Street \_\_\_\_\_  
 City, State \_\_\_\_\_  
 County \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone \_\_\_\_\_  
 Fax \_\_\_\_\_  
 Email \_\_\_\_\_

Species: \_\_\_\_\_

Breed: \_\_\_\_\_

**PLEASE WRITE ANIMAL ID CLEARLY ON MILK COLLECTION TUBE(S)**

## MILK SAMPLE SUBMISSION

Accession Number: \_\_\_\_\_

**Please fill out this form as completely as possible. Including detailed information about history and treatments will help expedite testing.**

### History/Treatments:

#### Individual Sample:

- Dry Cow
- Fresh Cow
- Mid Lactation Cow
- Teat End Injury

#### Herd Survey:

Pre-dip type/name: \_\_\_\_\_  
Post-dip type/name: \_\_\_\_\_  
Dry treatment type/name: \_\_\_\_\_

Date of last lactation treatment: \_\_\_\_\_

Herd Size: \_\_\_\_\_

Lactation treatment name: \_\_\_\_\_

BulkTank SCC: \_\_\_\_\_

### Test requested:

- Routine Aerobic QTR
- Routine Aerobic COM
- Routine Aerobic Bulk Tank (with Mycoplasma)
- Routine Aerobic Bulk Tank (without Mycoplasma)
- Mycoplasma
- Antibiotic Sensitivity
- Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Additional information or sample identification: