PENNSTATE

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

Accession No. _____
Data Entry _____
Case Coordinator_____
Date Submitted _____
Case Tracking # _____
Reference Lab _____
FOR LABORATORY USE ONLY

MASTITIS MILK QUALITY SUBMISSION

Owner/Company:
Name _____
Business Name _____
Street _____
City, State _____
County _____ **Zip:**_____
Phone _____
Fax _____
Email _____

Submitter/Service Person:
Name _____
Business Name _____
Street _____
City, State _____
County _____ **Zip:**_____
Phone _____
Fax _____
Email _____

Vet/Agent/Field Investigator:
Name _____
Business Name _____
Street _____
City, State _____
County _____ **Zip:**_____
Phone _____
Fax _____
Email _____

Other:
Name _____
Business Name _____
Street _____
City, State _____
County _____ **Zip:**_____
Phone _____
Fax _____
Email _____

Species: _____
Breed: _____

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: _____

Specimen Type(s)	**No. of Specimens**
☐ **Milk – Quarter**	_____
☐ **Milk - Composite**	_____
☐ **Bulk Tank**	_____
☐ **Referral Plate**	_____
☐ **Swab (Original)**	_____
☐ **Colostrum**	_____
☐ **Other**	_____
☐ **Other**	_____

Premise ID: _____

Dairy One? ☐ **Y** ☐ **N**
If Yes:
Center Name: _____
Herd Code: _____

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: _____

Lactation treatment name: _____

Herd Size: _____

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: