



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 _____

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: _____

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: