

## Dirofilarial Genetic Diversity Study Submission form

Clinic Name: \_\_\_\_\_

Clinician Name: \_\_\_\_\_

Clinician E-mail: \_\_\_\_\_ Clinic Phone Number: \_\_\_\_\_

Dog No	Patient Name	Client Last Name	Sample type (see below)	Antigen Status Pos/Neg	Patient ZIP code
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

For sample type, please enter one of the following in the appropriate column above:  
EDTA, Heparin, Whole Blood, Acid citrate dextrose, Other

1. Samples can be **stored refrigerated** for up to 2 weeks prior to submission.
2. At least **0.5ml of blood** is preferred.
3. Up to 10 samples can be submitted at the same time to save on shipping costs.
4. Samples do **not** need to be shipped on ice.
5. Please ship in **plastic collection tubes**.
6. Please **label** tubes clearly.
7. Please contact investigator if you have any questions.

Please mail samples to:



Mark Rishniw BVSc, MS, PhD, DACVIM  
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