



## TEST REQUEST SUBMISSION FORM

PRICES EFFECTIVE January 1, 2007

**HEMOPET / HEMOLIFE W. JEAN DODDS, DVM**

11330 MARKON DRIVE, GARDEN GROVE, CA 92841

Phone: (714) 891-2022 Fax: (714) 891-2123 BILLING: (714) 891-2022

<b>VETERINARIAN:</b>		<b>DATE:</b>
Clinic:		
Address:		
City:	State:	Zip:
Phone:	FAX:	Email:

<b>CLIENT:</b>		
Address:		
City:	State:	Zip:
Phone:	FAX:	Email:

**THE FOLLOWING INFORMATION IS CRITICAL FOR DR. DODDS' INTERPRETATION !!!**

Species (circle): **Canine** Feline Equine Other

Pet Name:		Breed: <b>Alaskan Klee Kai</b>	
Age:	Sex (circle): F FS M MN	Weight:	
REASON FOR TESTING & BRIEF HISTORY:			
ON MEDICATION (circle): YES NO If Yes, brief list:			
HOW MUCH?	HOW OFTEN?	BLOOD DRAWN ____ HRS POST PILL	

Check tests desired and enclose appropriate fees <b>DOLLARS</b>	<b>PRICES IN US</b>	<b>Cost</b>
____ <b>Thyroid Ab Profile (D8T)</b> (If on thyroid therapy, what dose and how many hours post-pill?) <b>and ADD ON TgAA (thyroglobulin autoantibody) to D8T</b>		<b>\$55.00</b> <small>(if participating in hypothyroidism research – additional EDTA tubes)</small>
<b>OR</b>		
____ <b>Thyroid Ab Profile (D8T); add on TgAA to D8T; and OFA Panel (86135)</b> <small>(include completed and signed OFA form, and separate check for OFA)</small>		<b>\$85.00</b>
____ <b>Other Tests (see next page)</b>		
<b>Additional amount as a Donation to HEMOPET</b>		\$ _____
<b>Total:</b>		\$ _____

Credit Card Account Number (all but Discover): \_\_\_\_\_ Type \_\_\_\_\_

Expiration Date: (Month & Year): \_\_\_\_\_ Authorized Signature: \_\_\_\_\_

**PRINT NAME** as it appears on your card: \_\_\_\_\_

\*Please call for availability and pricing of other Diagnostic Tests. Thank you!