

DM FLASH TEST REQUEST FORM

University of Florida
Veterinarian Medical Center
Room VS-50, 2015 SW 16th Avenue
Gainesville FL 32608
(352) 392-4700 Ext 4400

Referring Vet Information

Name: _____

Clinic Name: _____

Address: _____

Phone: _____

FAX _____

Email _____

Results will be sent to referring Veterinarian.

DM Test Requested

DM Flash Test: (for GSDs)

Flash Test including shipping

Flash Test not including shipping

RAPD DM test: (for Boxers, Corgis & Rhodesian Ridgebacks)

RAPD Test including shipping

RAPD Test not including shipping

Consult with referring veterinarian

Account # _____ **\$** _____

Payment methods: Check made out to **FVMFA**

Credit Card Number _____ / _____ / _____
Exp Date V# Last 3 digits on the back

Type: Visa MC Discover American Express

Card Holder Signature _____

I. OWNER INFORMATION

Name: _____ Phone: _____

Address _____ Cell: _____

Email: _____

II. PET INFORMATION

Name: _____ Age: _____ Breed: _____ Sex: _____

Animal ID (Tattoo, Microchip, etc.): _____

III. MEDICAL HISTORY

Diagnosis: _____ Date: _____

Diagnosed with DM: No Yes

Date of Consult: _____

Diagnostic Test Performed

CSF EMG

CT MRI

Myelograph Other

LAB USE ONLY

LDNA RAPD/ship

CDNA RAPD

CLEM

