

PLEASE USE BLACK INK

DOCTOR	DATE
HOSPITAL	
STREET OR P.O. BOX	
CITY, STATE, ZIP	
TELEPHONE NO. ()	FAX NO. ()
OWNER'S NAME	
ANIMAL'S NAME	
BREED	AGE
SPECIES	SEX

LOUISIANA ANIMAL DISEASE DIAGNOSTIC LABORATORY
P.O. Box 25070
Baton Rouge, LA 70894
Phone (225) 578-9777
FAX (225) 578-9784

Please indicate location of biopsies taken by an "X"
DORSAL VENTRAL



Please put Doctor's name, Owner's name and Animal's name on specimen vial.

BIOPSY FORM

CLINICAL HISTORY AND OBSERVATIONS:

Previous Submission (s) From This Animal Date _____ DL # _____ Please circle: alive died euthanized
