



RABIES ANTIBODY TEST REQUISITION FORM

Rabies Antibody Testing by the Fluorescent Antibody Virus Neutralisation Method (FAVN)

LABORATORY

To be filled by customer: (Only typewritten forms are accepted)

مختبر أبحاث
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البيطري
المركزي

DATE & TIME OF SAMPLE COLLECTION : _____
(IN DD/MM/YYYY FORMAT)

OWNER NAME: _____

CONTACT DETAILS: _____

VETERINARIAN NAME: _____

SUBMITTING CLINIC: _____

ADDRESS: _____

RESULTS TO NAME: _____

EMAIL/FAX: _____

INVOICE TO: _____

Results will be e-mailed/faxed unless an alternative method is selected.

Select preferred alternative, if required (There will be an additional charge) : POST COURIER NONE

IMPORT FROM _____ EXPORT TO _____

ANIMAL NAME: _____

MICROCHIP NUMBER: _____ SPECIES: _____

BREED: _____ AGE: _____ SEX: M / F

INDICATE LAST VACCINATION DETAILS (Date of last vaccination against rabies, vaccine name, name of manufacturer)

RABIES VACCINATION HISTORY (Please include up to 2 previous vaccination dates if available):

SIGNATURE OF VETERINARIAN: _____ DATE: _____ (DD/MM/YYYY)

Signature affirms that the above information is correct and the microchip number has been verified.
Test will be cancelled if sample tube is unlabelled or arrives without the microchip number.

*Due to stringent regulations, personnel at CVRL are not permitted to add or change information on the FAVN form. Once results are finalized, no changes to the information on the form can be made by the submitting clinic, even in the case of minor clerical errors. Please check spelling, microchip numbers and dates thoroughly before sending.

For CVRL use only:

CENTRAL VETERINARY RESEARCH LABORATORY

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c v r l @ c v r l . a e
w w w . c v r l . a e

DATE AND TIME OF ARRIVAL: _____ CASE ID: _____

INVOICE NO: _____ LAB NO: _____