

Clinical Pharmacology Laboratory

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Name: _____
Owner: _____
Case/Ref Number: _____
Species: _____
Breed: _____ Sex: _____
Age: _____ Weight: _____ kg lb

Veterinarian: _____
Clinic: _____
Mailing Address: _____
City, State Zip: _____
Telephone: (____) _____ Fax: (____) _____
Email: _____
Report Results Via: Fax Email Other: _____
 STAT (Additional Charge) Date Collected: _____

| <u>Test(s) Requested:</u> | <u>Peak & Trough</u> |
|--|--------------------------|
| <input type="checkbox"/> Bromide | <input type="checkbox"/> |
| <input type="checkbox"/> Cyclosporine* | <input type="checkbox"/> |
| <input type="checkbox"/> Keppra® (Levetiracetam)* <input type="checkbox"/> Extended Release | <input type="checkbox"/> |
| <input type="checkbox"/> Phenobarbital | <input type="checkbox"/> |
| <input type="checkbox"/> Zonisamide | <input type="checkbox"/> |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> |

*Recommend peak and trough first time monitoring to establish half-life.

Recommendations Needed? (No Charge): Yes No
Abnormal Lab Results: No Yes (please list): _____
Pertinent History (Please be brief): _____

Monitoring Purpose: Efficacy Toxicity Routine Check

Other Drugs in use: _____

Clinical Signs Controlled? Yes No: Date of most recent relapse: _____

- **NO SERUM SEPARATOR TUBES.** Most tests (except Cyclosporine) require 0.5ml serum or plasma, please see *Submission Information* for details.
- Please provide dosing, collection, and response information even if you do not want recommendations to assist delineation of therapeutic ranges.

Complete this section for drugs other than bromide or cyclosporine.

Drug: _____ Preparation: Name Brand Generic Compounded
Route: _____ Manufacturer/Pharmacy: _____
Dose: _____ mg/kg mg Every: 24hrs 12hrs 8hrs Other (____) Duration @ current dose: _____ d/m/y
Peak: Last dose @ _____ Sample collected @ _____ Trough: Last dose @ _____ Sample collected @ _____

Complete this section for drugs other than bromide or cyclosporine.

Drug: _____ Preparation: Name Brand Generic Compounded
Route: _____ Manufacturer/Pharmacy: _____
Dose: _____ mg/kg mg Every: 24hrs 12hrs 8hrs Other (____) Duration @ current dose: _____ d/m/y
Peak: Last dose @ _____ Sample collected @ _____ Trough: Last dose @ _____ Sample collected @ _____

BROMIDE (Complete this section if monitoring Bromide.)
Preparation: KBroVet Other (____) Route: _____ Steady State (>2.5months) 1 month
Dose: _____ mg/kg mg Every: 24hrs 12hrs 8hrs Other (____) Duration @ current dose: _____ d/m/y
Loading Dose: No Yes: Dose: _____ mg/kg Frequency: _____ Duration: _____ d/m/y

CYCLOSPORINE (EDTA Whole Blood) (Complete this section if monitoring Cyclosporine.)
Preparation: Atopica Neoral Generic Compounded Manufacturer/Pharmacy: _____
Dose: _____ mg/kg mg Every: 24hrs 12hrs 8hrs Other (____) Duration @ current dose: _____ d/m/y
Peak: Last dose @ _____ Sample collected @ _____ Trough: Last dose @ _____ Sample collected @ _____
If result is greater than assay range, please dilute (additional charge): No Yes Call first

Lab Use Only: _____ Revised May 2012
Date Received: _____ Accession# _____