

Clinical Pharmacology Laboratory

1500 Wire Rd, 214 SRRC
College of Veterinary Medicine
Auburn University, AL 36849



Phone: (334) 844-7187
Fax: (334) 844-7188
clinpharm@auburn.edu

www.vetmed.auburn.edu/clinical-pharmacology-lab

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"/>
<input type="checkbox"/> Extended Release	
<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 Monitoring Purpose: Efficacy Toxicity Routine Check
Abnormal Lab Results: No Yes (please list): _____
Pertinent History (Please be brief): _____

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.) Route: _____
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# _____