# UMC CANINE DNA TEST REQUEST

**Blood – Tissue – FTA card - other _____** Breed: **Dachshund** (variety) _____

Registered Name _____ Call name _____

Reg# _____ Birth Date _____ Male / Female - - Intact / Neutered

Microchip or Tattoo: _____ Color _____

**Test Being Requested** (please circle) **NCL** – Neuronal Ceroid Lipofuscinosis

**PRA** – Progressive Retinal Atrophy

Owner: name _____ Veterinarian _____

address _____ _____

cty-st-zip _____ _____

phone (day) _____ _____

phone (eve) _____ _____

cell _____ Fax _____

e-mail _____ _____

***Results are reported via email with certificate attached – please provide complete, legible email address!!***

**Report test results to** *(please circle)*: Owner Veterinarian Both

Has this dog been diagnosed as likely to be affected with the disease being tested for? Yes No

Does this dog exhibit any symptoms of the disease being tested for? Yes No

If Yes, please list observed symptoms _____

_____

Have any relatives of this dog been diagnosed as AFFECTED with this disease? Yes No Don't Know

If Yes, what relative(s)? Sire Dam Sibling Grandparent other _____

Have any relatives of this dog been DNA-tested as a CARRIER for the disease? Yes No Don't Know

If Yes, what relative(s)? Sire Dam Sibling Grandparent other _____

Has this dog been diagnosed with, or does it show symptoms of any other disease, abnormality, or temperament issue? (*Please list*) _____

Other Comments / Questions / Concerns? _____

I submit this sample and pedigree for the purpose of DNA testing; I understand that DNA left over following the test may be stored for potential future research; I understand that the results of this test will be reported only to the owner listed on this form and to the veterinarian (if requested) listed here, via email or FAX; and I have supplied complete and accurate information, to the best of my knowledge.

Signed: _____ date _____

***Testing Fee:***

- NCL test only – fee is $65.00 …… _____
- PRA test only – fee is $65.00 …… _____
- Both NCL and PRA tests from this sample – fee is $100.00 …… _____

**PAYMENT INFORMATION:**

☐ Check or money order payable to "University of Missouri" enclosed

OR ☐ Charge to VISA-MasterCard-Discover-AmEx Card# _____

Cardholder name: _____ Exp Date: _____