

OPTIGEN Blood Sample/DNA Test Request Form**INSTRUCTION**

This form is for submitting a test application to OptiGen by mail or fax. Feel free to duplicate and distribute this form to others. Please complete the form carefully and be sure to obtain the required signatures on it, then include one copy with payment in the sample package you send to OptiGen. Please read and print a copy of the Ship Sample instructions for your veterinarian (www.optigen.com). **Ship sample(s) to OptiGen, 767 Warren Road, Suite 300, Ithaca, NY 14850.** If you want to submit your application online, please use our online form

YES **NO**... Send a report copy to the doctor listed in section 4 and/or section 10.
(You must include an addressed stamped envelope for each report requested.)

SECTION 1: OWNER INFORMATION

Name: First _____ MI _____ Last _____
 Address: _____
 City: _____ State/Province: _____
 Country: _____ Zip/Postal Code: _____
 Day Phone: _____ Evening Phone: _____
 Day Fax: _____ Evening Fax: _____
 Email: _____
 Co-Owner Names: First _____ MI _____ Last _____

SECTION 2: REPORTS

Send results by (select one): Mail Email Day Fax Evening Fax

Results will not be provided by phone. Certificates for dogs that test genetically normal will be sent by mail. **Test results will be reported to genetic registries only according to policy determined by each parent club.**

SECTION 3: DOG IDENTIFICATION (Indicate "N/A" if question not applicable)

Breed: _____ Call Name: _____
 Registered Name: _____
 Reg #: _____
 Birthdate: ___/___/___ (mon/day/yr) Sex: Female Male
 Tattoo/Chip#: _____ CERF#/Other Eye Reg.#: _____
 Reg. Name of Sire: _____
 Reg. # of Sire: _____
 Reg. Name of Dam: _____
 Reg. # of Dam: _____

SECTION 4: DISEASE HISTORY

Date of last exam by an ophthalmologist (mon/day/yr): ___/___/___ Never Examined

Eye Disease Diagnosed: Collie Eye Anomaly/Choroidal Hypoplasia Comments: _____
 None Other Cone Degeneration _____
 Congenital Stationary Night Blindness _____
 Progressive Retinal Atrophy _____
 Other Diagnosis: Canine Leukocyte Adhesion Deficiency Myotonia Congenita
 None Other Cystinuria Narcolepsy
 Phosphofructokinase Deficiency
 Pyruvate Kinase Deficiency

If available, please provide information on the examining ophthalmologist or veterinary specialist.

Name: _____
 City, State/Province: _____

- Page 1 -

SECTION 5: BLOOD SAMPLE INFORMATION Blood sample is already at OptiGen under a long-term storage agreement. Blood sample will be submitted with this request**SAMPLE STORAGE**

Optional 10 year storage of frozen sample can be requested for an additional \$35.

No guarantee is made that this sample will be usable for the desired purpose when it is retrieved.Request long-term storage of sample: Yes \$35 No**SECTION 6: TEST(S) REQUESTED**

- American Cocker Spaniels** Phosphofructokinase Deficiency - PFK test - \$80
 Progressive Retinal Atrophy - prcd Mutation Test for PRA - \$195
- American Eskimo Dog** Progressive Retinal Atrophy - prcd Mutation Test for PRA - \$195
- Australian Cattle Dog** Progressive Retinal Atrophy - prcd Mutation Test for PRA - \$195
- Australian Shepherd** Collie Eye Anomaly/Choroidal Hypoplasia - CEA/CH test - \$180
- Australian Stumpy Tail Cattle Dog** Progressive Retinal Atrophy - prcd Mutation Test for PRA - \$195
- Basenjis** Pyruvate Kinase Deficiency - PK test - \$80
- Border Collie** Collie Eye Anomaly/Choroidal Hypoplasia - CEA/CH test - \$180
- Briard** Congenital Stationary Night Blindness - CSNB test - \$135
- Bullmastiff** Progressive Retinal Atrophy - Dominant test for PRA - \$120
- Cardigan Welsh Corgi** Progressive Retinal Atrophy - rcd3 test for PRA - \$80
- Chesapeake Bay Retriever** Progressive Retinal Atrophy - prcd Mutation Test for PRA - \$195
- Dachshund** Narcolepsy - NARC test - \$130
- Doberman Pinscher** Narcolepsy - NARC test - \$130
- English Cocker Spaniel** Progressive Retinal Atrophy - prcd Mutation Test for PRA - \$195
- English Springer Spaniels** Phosphofructokinase Deficiency - PFK test - \$80
- Entlebucher Mountain Dog** Progressive Retinal Atrophy - prcd Mutation Test for PRA - \$195
- German Shorthaired Pointer** Cone Degeneration - cd test - \$160
- Irish Red & White Setter** Canine Leukocyte Adhesion Deficiency - CLAD test - \$135
 Progressive Retinal Atrophy - rcd1 test for PRA - \$120
- Irish Setter** Canine Leukocyte Adhesion Deficiency - CLAD test - \$135
 Progressive Retinal Atrophy - rcd1 test for PRA - \$120
- Labrador Retriever** Narcolepsy - NARC test - \$130
 Progressive Retinal Atrophy - prcd Mutation Test for PRA - \$195
- Lancashire Heeler** Collie Eye Anomaly/Choroidal Hypoplasia - CEA/CH test - \$180
- Mastiff** Progressive Retinal Atrophy - Dominant test for PRA - \$120
- Miniature Poodle** Progressive Retinal Atrophy - prcd Mutation Test for PRA - \$195
- Miniature Schnauzer** Progressive Retinal Atrophy - Type A test for PRA - \$160
- Newfoundland** Cystinuria - cystinuria test - \$80
- Nova Scotia Duck Tolling Retriever** Progressive Retinal Atrophy - prcd Mutation Test for PRA - \$195
- Portuguese Water Dog** Progressive Retinal Atrophy - prcd Mutation Test for PRA - \$195
- Rough Collie** Collie Eye Anomaly/Choroidal Hypoplasia - CEA/CH test - \$180
- Samoyed** Progressive Retinal Atrophy - XL test for PRA - \$150
- Shetland Sheepdog** Collie Eye Anomaly/Choroidal Hypoplasia - CEA/CH test - \$180
- Siberian Husky** Progressive Retinal Atrophy - XL test for PRA - \$150
- Sloughi** Progressive Retinal Atrophy - Sloughi test for PRA - \$80
- Smooth Collie** Collie Eye Anomaly/Choroidal Hypoplasia - CEA/CH test - \$180
- Toy Poodle** Progressive Retinal Atrophy - prcd Mutation Test for PRA - \$195

- Page 2 -

SECTION 7: CERF or OFA DNA REGISTRY FEE

If you are a US resident, and your dog is one of these **Australian Cattle Dog Briard Irish Setter** -- you must include this fee in your application in accordance with the breed club's guidelines.
Owners from other countries with these breeds may choose to have their dog's DNA registered with CERF or OFA by paying the fee.

Australian Cattle Dog -- \$7.50/test Briard -- One test requested \$15. Each additional test requested on one dog \$10 Irish Setter -- One test requested \$15. Each additional test requested on one dog \$10

Number of tests requested _____ Total CERF or OFA Fee \$ _____

SECTION 8: PAYMENT OF FEES (no EuroCheques please)

Total cost: \$ _____ How will you be paying?
 ___ Check or Money Order in US dollars payable to OptiGen, LLC is enclosed
 ___ Visa or ___ Mastercard

Card #: _____ Expiration Date: _____
 Name shown on card: _____ Signature: _____

SECTION 9: LIMITED WARRANTY AND DISCLAIMER

OptiGen warrants its test results to be accurate for the blood sample obtained from this dog alone, as identified by the information given on this form. In the event of a valid claim, owner's sole remedy is a refund of the fee paid.

IN NO EVENT SHALL OPTIGEN BE LIABLE FOR INDIRECT, CONSEQUENTIAL OR INCIDENTAL DAMAGES OF ANY KIND. Any claim must be asserted within two years of the report of the test results.

SECTION 10: CERTIFICATION AND SIGNATURES

The undersigned hereby certifies that the dog described above is the same dog whose **permanent ID** (if available) is stated above, whose blood sample is submitted and labeled with this name and whose information is given on this form, and that all information is accurate to the best of my knowledge. I understand that additional blood samples may be required to complete this test.

I authorize OptiGen to release test results to the officially sponsored registry for my breed in my country, or to another country's registry if I elected to pay the required fee. I hereby release forever the responsible breed club, the operators of the registry and OptiGen from any and all liability resulting from the transfer of this data.

I accept all conditions stated in this multi-page application form.

Owner's Signature: _____ Date (mon/day/yr): ___/___/___
 Blood Sample Collected by: ___ Veterinarian ___ Technician Date Collected: ___/___/___
 Veterinarian's or Vet Technician's Signature: _____ Date: ___/___/___
 PRINT Veterinarian's or Vet Technician's Name: _____
 Hospital/Clinic (if applicable): _____
 Address: _____