

LONG TERM STORAGE FOR GERMAN PINSCHER CATARACT STUDY

INSTRUCTIONS

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. Ship sample(s) to OptiGen, 767 Warren Road, Suite 300, Ithaca, NY 14850.

SECTION 1: OWNER INFORMATION

Name: first _____ initial _____ last _____
Address: _____
City: _____ State/Province: _____
Country: _____ Zip/Postal Code: _____
Day Phone: _____ Evening Phone: _____
Fax: _____
Email: _____
Co-Owner first _____ initial _____ last _____
Names: _____

SECTION 2: REPORTS

Mail ALL reports are mailed to the owner. For additional rapid reports, select one: Email or Fax

Results will not be provided by phone. Test results will be reported to genetic registries only according to policy determined by each parent club as described in the Registry Table. To request additional, mailed reports to anyone other than the owner or qualified registry, please include an addressed envelope for each name and address.

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

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

Registered Name _____

of Dam:

Registered _____

Number of Dam:

SECTION 4: DISEASE HISTORY

Date of last exam by an ophthalmologist (mon/day/yr): ___/___/___ or ___ never examined

Eye Disease History:

<input type="checkbox"/> None	<input type="checkbox"/> Canine Multifocal Retinopathy	Comment:
<input type="checkbox"/> Other	<input type="checkbox"/> Cataracts	_____
	<input type="checkbox"/> Collie Eye Anomaly/Choroidal Hypoplasia	_____
	<input type="checkbox"/> Cone Degeneration	
	<input type="checkbox"/> Congenital Stationary Night Blindness	
	<input type="checkbox"/> Primary Lens Luxation	
	<input type="checkbox"/> Progressive Retinal Atrophy	
	<input type="checkbox"/> Retinal Folds	

Other Disease:

<input type="checkbox"/> None	<input type="checkbox"/> Other	<input type="checkbox"/> Canine Leukocyte Adhesion Deficiency	<input type="checkbox"/> Congenital Stationary Night Blindness
		<input type="checkbox"/> Cystinuria	<input type="checkbox"/> Cystinuria
		<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Epilepsy
		<input type="checkbox"/> Familial Nephropathy	<input type="checkbox"/> Familial Nephropathy
		<input type="checkbox"/> Myotonia Congenita	<input type="checkbox"/> Myotonia Congenita

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

Name: _____

City, _____

State/Province: _____

FEE FOR GPCA SUBSIDIZED SAMPLE STORAGE IS \$15.00

SECTION 5: SAMPLE INFORMATION

Paperwork is already at OptiGen because the dog was previously submitted.

Sample (blood, semen, or cheek swabs) will be submitted with this request.

Sample Storage -- Optional 10 year storage of frozen sample (BLOOD ONLY) 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 GPCA SUBSIDIZED \$15. YES

Dog's Call Name: _____

Owner's Signature: _____ Date (mon/day/yr): ___/___/___

Sample Certified by: Vet/Tech Witness Date Collected: ___/___/___

Signature: _____ Date ___/___/___

Print Name: _____

Hospital/Clinic (if applicable): _____

Address: _____

SECTION 10: Payment of Fees (no EuroCheques please)

Total: \$ _____ How will you be paying?

Check or Money Order in US dollars payable to OptiGen, LLC is enclosed

Visa **MasterCard**

Credit Card
Number: _____

Expiration
Date: _____

Name on Card: _____

Signature: _____