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**MISSISSIPPI STATE UNIVERSITY COLLEGE OF VETERINARY MEDICINE**

**Canine Cyclosporine Pharmacodynamic Assay (Immune Function via PCR Assay for IL-2)**

Please type in information and then print it. If form is filled in by hand, please use only capital letters to fill the blanks.

**Veterinarian Personal Information**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Telephone**  | **Fax** | **Email** |
| Click or tap here to enter text. |  Click here to enter. | Click here to enter. | Click or tap here to enter text. |
| **Veterinary Clinic Address** | Click or tap here to enter text. |

**Report results via (chose one):** [ ]  **Email** [ ]  **Fax**

**Patient Information**

|  |  |
| --- | --- |
| **Dog’s Name** | **Owner’s Name** |
| Click or tap here to enter text. | Click or tap here to enter text. |
| **Case/Ref. Number**  | **Breed**  | **Age (Years)** | **Weight (Kg)** | **Gender (M/F)** | **Neutered (Y/N)** |
| Click or tap here to enter text. | Click here to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click here to enter text. |
| **Current Diagnosis** | Click or tap here to enter text. |
| **Current History (please fill in all the necessary information)*****NOTE: Medication history goes in following section.*** | Click or tap here to enter text. |
| **Changes from previous history?****(if previous samples submitted, please fill in all significant changes)** | Click or tap here to enter text. |
| **Clinical Signs Controlled? (Y/N)** | **In Remission? (Y/N, plus extra details if needed)** |
| Click or tap here to enter text. | Click or tap here to enter text. |

**Current Treatment**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Drug Name (excluding cyclosporine)**  | **Dose (mg)** | **Frequency**  | **Drug Name**  | **Dose (mg)** | **Frequency**  |
| **1.**Click or tap here to enter text. | Enter text. | **Every\_\_\_\_hrs** | **6.**Click or tap here to enter text. | Enter text. | **Every\_\_\_\_hrs** |
| **2.**Click or tap here to enter text. | Enter text. | **Every\_\_\_\_hrs** | **7.**Click or tap here to enter text. | Enter text. | **Every\_\_\_\_hrs** |
| **3.**Click or tap here to enter text. | Enter text. | **Every\_\_\_\_hrs** | **8.**Click or tap here to enter text. | Enter text. | **Every\_\_\_\_hrs** |
| **4.**Click or tap here to enter text. | Enter text. | **Every\_\_\_\_hrs** | **9.**Click or tap here to enter text. | Enter text. | **Every\_\_\_\_hrs** |
| **5.**Click or tap here to enter text. | Enter text. | **Every\_\_\_\_hrs** | **10.**Click or tap here to enter text. | Enter text. | **Every\_\_\_\_hrs** |

**Sample Information**

|  |  |  |
| --- | --- | --- |
| **Date of Collection (m/d/y)** | **Time (am/pm)** | **How Many Hours AFTER Cyclosporine Administration?**  |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

**Cyclosporine Current Treatment (check relevant box):**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Atopica®*** [ ]  | ***Neoral®*** [ ]  | ***Sandimmune®*** [ ]  | **Compounded** [ ]  | **Generic** [ ]  |
| **Modified (microemulsified, ultramicronized)?** | **Yes** [ ]  **No** [ ]  **Don’t Know** [ ]  |
| **Manufacturer** | Click or tap here to enter text. |
| **Compounding Pharmacy (only for compounded cyclosporine)** | Click or tap here to enter text. |
| **Dose (mg/kg)** | **Frequency** | **Start Date (m/d/y)** |  |
| Click or tap here to enter text. | **Every\_\_\_\_\_hrs** | Click or tap here to enter text. |
| **Any Side-effects Observed? Yes** [ ]  **No** [ ]  **(If yes, please cite):**  | Click or tap here to enter text. |

