

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 Information:** | **Billing Information (must complete for samples to be processed):** |
| **Name:** | **Clinic Name:** |
| **Street Address:** |
| **City, State, ZIP:** |
| **Email:** | **Phone Number:** |

**Patient Information**

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

**Current Treatment**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Drug Name (excluding cyclosporine)** | **Dose (mg)** | **Frequency** | **Drug Name** | **Dose (mg)** | **Frequency** |
|  |  | **Every hrs** |  |  | **Every hrs** |
|  |  | **Every \_hrs** |  |  | **Every hrs** |
|  |  | **Every \_hrs** |  |  | **Every hrs** |
|  |  | **Every \_hrs** |  |  | **Every hrs** |
|  |  | **Every hrs** |  |  | **Every hrs** |

**Sample Information**

|  |  |  |
| --- | --- | --- |
| **Date of Collection (m/d/y)** | **Time (am/pm)** | **How Many Hours AFTER Cyclosporine Administration?** |
|  |  |  |

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

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ***Atopica®*** |  |  | | | ***Neoral®*** |  | |  | | | | ***Sandimmune®*** | |  | |  | **Compounded** | |  |  | **Generic** |  |  |
| **Modified (microemulsified, ultramicronized)?** | | | | | | | **Yes** | |  | **No** | | |  | | **Don’t Know** | | | |  |  | | | |
| **Manufacturer** | | |  | | | | | | | | | | | | | | | | | | | | |
| **Compounding Pharmacy (only for compounded cyclosporine)** | | | | | | | | | | |  | | | | | | | | | | | | |
| **Dose (mg/kg)** | | | | **Frequency** | | | | | | | **Start Date (m/d/y)** | | | | | | |  | | | | | |
|  | | | | **Every hrs** | | | | | | |  | | | | | | |
| **Any Side-effects Observed? Yes No**  **(If yes, please cite):** | | | | | |  | | | | | | | | | | | | | | | | | |

Text

Description automatically generated

CONTACT

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*Please feel free to contact us if you have any questions regarding sample submission or results.*

CLINICIANS

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