

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):** |  |



CONTACT

Lakshmi Narayanan, Senior Research Associate, lna45@msstate.edu; (662) 312-8138 (laboratory)

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

CLINICIANS

Dr. Todd Archer, Professor: tarcher@cvm.msstate.edu; (662) 325-1266

Dr. Andrew Mackin, Professor and Department Head; mackin@cvm.msstate.edu; (662) 418-3277