REQUEST FOR TECHNICAL ASSISTANCE or SERVICE

Department of Comparative Medicine

Requests for technical assistance or services from the DCM or to schedule the use of the DCM experimental surgery or radiology facilities must be in writing and signed by the Principal Investigator or authorized assistant. Deliver the completed form to the Department of Comparative Medicine, 992 MSB as far in advance as possible. The form may be faxed to the DCM @ 460-7783.

Complete the following information:

Date _____

Principal Investigator _____ (Please print) Protocol # _____

Telephone number _____ Pager/Cell Phone Number _____

Species _____ Animal/Cage ID# _____ Room # _____

Date and Time for Requested Service _____ am/pm

Check appropriate items below and provide descriptive information where requested (attach additional sheets if required)**:**

☐ Administer medications (medication, dose, route, frequency): _____

☐ Anesthetize (agent, dose [per protocol]): _____

☐ Deliver to (building and room#): _____

☐ Collect fluids or materials

- ❍ ascites fluid _____ ml
- ❍ blood _____ ml ☐ No anticoagulant ☐ Anticoagulant (type & quantity) _____
- ❍ feces _____ gm
- ❍ urine _____ ml
- ❍ _____ _____ ml

☐ Euthanize (agent, method [per protocol] _____

- ❍ Save and notify when completed
  - ☐ Refrigerate
  - ☐ Freeze
- ❍ Discard

☐ Fast animal(s):

	No food	No water	No food or water	
❍ Overnight (12-16 hours)	☐	☐	☐	
❍ 24 hours	☐	☐	☐	(requires approval by clinical veterinary staff)
❍ _____	☐	☐	☐	(may require approval by clinical veterinary staff)

☐ Pre-medication required? NO YES (Type and dosage _____)

☐ Radiology procedures *Complete reverse side: Request to Schedule Experimental Surgery or Radiology Facilities*

☐ Recovery pen/cage required? NO YES

☐ Restraint/manipulation (describe) _____

☐ Surgical procedure (to be performed in DCM) *Complete reverse side: Request to Schedule Experimental Surgery or Radiology Facilities*

☐ Other _____

☐ Calendar schedule is attached for multiple procedure request covering an extended period of time.

_____

Signature of Principal Investigator or Authorized Assistant ***REQUIRED***

(1/98)

REQUEST TO SCHEDULE EXPERIMENTAL SURGERY or RADIOLOGY FACILITIES
Department of Comparative Medicine

Please check appropriate item(s) below and provide descriptive information as requested.

☐ SURGERY

Location

- ○ Acute Surgery Facility [Non-survival procedure]
- ○ Aseptic Surgery Facility [Survival procedure (requires completed POST-PROCEDURE CARE RECORD)]
- ○ Aseptic Surgery Facility [Survival, multiple procedure (requires specific IACUC approval & completed POST-PROCEDURE CARE RECORD)]

Procedures to be carried out

○ Thoracic: describe procedures: _____

○ Abdominal: describe procedures: _____

○ Other : describe procedures: _____

Anesthesia

Type, dose and route of administration: _____

Administered by ○ DCM personnel ○ Research personnel (identify): _____

Is ventilation required? ○ Yes ○ No Anticipated duration of surgery: _____

Animal surgical prep & positioning

○ Standard surgical prep ○ by DCM personnel ○ by research personnel/investigator

○ Animal position:

Elevation

- ❑ Flat
- ❑ Head elevated
- ❑ Head lowered
- ❑ _____

Position

- ❑ Dorsal exposure
- ❑ Ventral exposure
- ❑ Lateral exposure
  - ❍ right side
  - ❍ left side
- ❑ _____

Instrument pack

○ Major ○ Necropsy
○ Cut-down ○ _____
○ Dental ○ _____

Medical Gases

○ Air ○ Oxygen
○ Nitrogen ○ _____
○ Nitrous oxide ○ _____

Monitoring equipment (Note: not all equipment may be available)

○ Respiration ○ Pulse Oximeter
○ Temperature ○ ECG
○ Blood Pressure ○ Other _____

Parenteral Fluids

Type _____ Dose/Rate _____ Route _____
Type _____ Dose/Rate _____ Route _____
Type _____ Dose/Rate _____ Route _____

General Equipment

○ Cautery ○ Heating pads ○ _____
○ Suction ○ IV administration setup ○ _____
○ Gas anesthesia ○ Operating microscope ○ _____

☐ RADIOLOGY

Area to be radiographed: _____ **# of exposures required**: _____

Animal position

- ○ AP
- ○ Lateral
- ○ Oblique
- ○ Other _____

Contrast media YES NO

Type _____

Route _____

Special procedures

Specify: _____