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 ____________________________ 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

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

Procedures to be carried out
- O Thoracic: describe procedures: ________________________________
- O Abdominal: describe procedures: ________________________________
- O Other: describe procedures: ________________________________

Anesthesia
Type, dose and route of administration: ________________________________
Administered by
- O DCM personnel
- O Research personnel (identify): ________________________________
Is ventilation required?  O Yes  O No  Anticipated duration of surgery: ________________________________

Animal surgical prep & positioning
- O Standard surgical prep  O by DCM personnel  O by research personnel/investigator
- O Animal position:

<table>
<thead>
<tr>
<th>Elevation</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flat</td>
<td>Dorsal exposure</td>
</tr>
<tr>
<td>Head elevated</td>
<td>Ventral exposure</td>
</tr>
<tr>
<td>Head lowered</td>
<td>Lateral exposure</td>
</tr>
<tr>
<td></td>
<td>right side</td>
</tr>
<tr>
<td></td>
<td>left side</td>
</tr>
</tbody>
</table>

Instrument pack
- O Major
- O Cut-down
- O Dental
- O Necropsy

Medical Gases
- O Air
- O Oxygen
- O Nitrogen
- O Nitrous oxide

Monitoring equipment (Note: not all equipment may be available)
- O Respiration
- O Pulse Oximeter
- O Temperature
- O ECG
- O Blood Pressure
- O Other

Parenteral Fluids
- O Type
- O Dose/Rate
- O Route

General Equipment
- O Cautery
- O Suction
- O Gas anesthesia
- O Heating pads
- O IV administration setup
- O Operating microscope

☐ RADIOLOGY

Area to be radiographed: ____________________________________________ # of exposures required: ________________

Animal position
- O AP
- O Lateral
- O Oblique
- O Other

Special procedures
Specify: ________________________________

Contrast media
- O YES
- O NO

Type
Route

☐