



Three Counties Equine Hospital LLP

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REQUEST FOR LABORATORY EXAMINATION

Referring Practice:

Tel

Fax

Clinician:

Date sample collected:

Name of horse:

Name of owner:

Samples referred

Examinations required

For Laboratory Use

Date sample received:

Lab code number:

Comments on sample at arrival:

Results:

Date result telephoned/faxed:

L J Kearns MVB MRCVS
C C Rea BVM&S MRCVS
A J C Harrison BVSc Cert EP Cert VA MRCVS
G N Potts BVetMed MRCVS
M Georgetti BVSc MACVSc MRCVS

Assisted By:
L J Harrison BVSc PhD Cert EO MRCVS
J L Robinson BVSc MRCVS
J Campbell BVMS MRCVS
C Gilbert MA Vet MB MRCVS

A Richardson BVSc MRCVS
F Georgetti BVM&S MRCVS
C Williams BVMS MRCVS
R Wall BVMS, MRCVS