IPNV Virus Isolation

Date sent: Site Address: Tel: Fax:	Invoice Address (if different from site address): Tel: Fax:

Sample type (please tick)

Milt	Ovarian Fluid	Kidney	Other
☐	☐	☐	☐

No	Sample Ref	Biobest Ref	No	Sample Ref	Biobest Ref
1			16		
2			17		
3			18		
4			19		
5			20		
6			21		
7			22		
8			23		
9			24		
10			25		
11			26		
12			27		
13			28		
14			29		
15			30		

Biobest Use Only

Date of Receipt:	Form No:	
No. of Samples:	Rep:	Invoice:
Booked in:	Interim QC (if required):	
	Final QC:	
	Interim Fax (if required):	Date interim report faxed (if required):
	Final Fax:	Date final report faxed:

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