

Marmottes Sassièrè/ Marmots Sassièrè

 Date: 23/05/2015

 Time: 9 h 15

 N° fiche/sheet: 131

Opérateur/ Handling: _____

 N° individu: 1462

 capture id: 9297

Territoire: <u>Z</u> Territory	Recapture yes <input checked="" type="checkbox"/> no <input type="checkbox"/>	Statut social Dominant <input type="checkbox"/> Sub <input type="checkbox"/> unknown <input type="checkbox"/>
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Measures Masse corporelle / Body mass (g) <u>2150g</u> L. mandibule / Jaw (mm) _____ L. Patte ant. / Forefoot (mm) _____ L. Cubitus / Ulna (mm) _____ L. Patte post. / Hindfoot (mm) _____ L. Tibia (mm) _____ L. TC / Body length (cm) _____ Larg. Tête zygomatique / Zygomatic width (mm) _____ Larg. Bassin / Basin width (mm) _____ Dist. Ano-Génitale (cm) (marmotton/pup only) _____

Marking	Transpondeur n° <u>956-3015609</u>	Paint _____ Bes
	Metal n° _____ Oreille / ear <u>OD</u>	
	Plastic n° _____ Oreille / ear _____ color _____	
	Implant yes <input type="checkbox"/> no <input type="checkbox"/>	

Age	0 Marmotton <input type="checkbox"/> Pup 1 an <input type="checkbox"/> Yearling	2 ans <input checked="" type="checkbox"/> 2 years old ≥ 3 ans <input type="checkbox"/> ≥ 3 y
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Echantillons / Samples : nbr + étiquette / label	
Feces <input checked="" type="checkbox"/> <input type="checkbox"/> Poils / Hair <input type="checkbox"/> Biopsy <input type="checkbox"/> <input type="checkbox"/> TV / Green tube <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> TR / Red tube <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frotti / Blood smear <input type="checkbox"/> <input type="checkbox"/>	Eurytic <input type="checkbox"/> Leucotic <input type="checkbox"/> Hematocyte <input type="checkbox"/> Jugal <input type="checkbox"/> <input type="checkbox"/> Bucal <input type="checkbox"/> <input type="checkbox"/> Anal <input type="checkbox"/> <input type="checkbox"/>

Statut Repro	Male <input type="checkbox"/> Scrotal yes <input type="checkbox"/> no <input type="checkbox"/> unknown <input type="checkbox"/>	Female <input checked="" type="checkbox"/> Allaitante yes <input type="checkbox"/> Lactating no <input type="checkbox"/> unknown <input type="checkbox"/>
		Gestante yes <input type="checkbox"/> Pregnant no <input type="checkbox"/> unknown <input type="checkbox"/>

Hemato TV extract: nb: _____ TR extract: nb: _____ Hfot: _____ Hematie: _____

Remarques / remarks

Extraction GB <input type="checkbox"/> <input type="checkbox"/>	Stress <input type="checkbox"/>
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Action pose <input type="checkbox"/> dépose <input type="checkbox"/> H début/start: _____	Implantation id: intra-abdo <input type="checkbox"/> ss-cut <input type="checkbox"/> H fin/end: _____	Position: Abdo <input type="checkbox"/> cou <input type="checkbox"/>	Implant id: n° _____	Type implant: vienne <input type="checkbox"/> ibutton <input type="checkbox"/> starr-oddi S <input type="checkbox"/> starr-oddi L <input type="checkbox"/>
Comments:				
Action pose <input type="checkbox"/> dépose <input type="checkbox"/> H début/start: _____	Implantation id: intra-abdo <input type="checkbox"/> ss-cut <input type="checkbox"/> H fin/end: _____	Position: Abdo <input type="checkbox"/> cou <input type="checkbox"/>	Implant id: n° _____	Type implant: vienne <input type="checkbox"/> ibutton <input type="checkbox"/> starr-oddi S <input type="checkbox"/> starr-oddi L <input type="checkbox"/>
Comments:				
Action pose <input type="checkbox"/> dépose <input type="checkbox"/> H début/start: _____	Implantation id: intra-abdo <input type="checkbox"/> ss-cut <input type="checkbox"/> H fin/end: _____	Position: Abdo <input type="checkbox"/> cou <input type="checkbox"/>	Implant id: n° _____	Type implant: vienne <input type="checkbox"/> ibutton <input type="checkbox"/> starr-oddi S <input type="checkbox"/> starr-oddi L <input type="checkbox"/>
Comments:				

Surgery Début: _____ Fin: _____ Injection: _____ H: _____ Injection: _____ H: _____ Anhest. Local (Lurocaïne): _____ Anti-infl (Metacam): _____ H: _____ Antibio (Baytril): _____ H: _____	Stress PS1 <input type="checkbox"/> Injection DM: Heure: _____ PS <input type="checkbox"/> Heure: _____ Injection ACTH: Heure: _____ PS <input type="checkbox"/> Heure: _____ PS <input type="checkbox"/> Heure: _____
Desimplantation N° implant sous-cut: _____ N° implant Intra-abdo: _____ Implantation N° implant Intra-abdo: _____ Autres: _____	Comments: