

Marmottes Sassièrè/ Marmots Sassièrè

Date: 28/05/2015

Time: 17h30

N° fiche/sheet: 200

Opérateur/ Handling: _____

N° individu: 1623

capture id: 9335

Territoire: <u>A</u> Territory	Recapture yes <input checked="" type="checkbox"/> no <input type="checkbox"/>	Statut social Dominant <input type="checkbox"/> Sub <input checked="" type="checkbox"/> unknown <input type="checkbox"/>
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Measures

Masse corporelle / Body mass (g)	<u>1650</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>056-3041029</u>	Paint <u>AV</u>
	Metal n° _____ Oreille / ear <u>OD</u>	<u>Rouge</u>
	Plastic n° _____ Oreille / ear _____ color _____	
	Implant yes <input type="checkbox"/> no <input type="checkbox"/>	

Age	0 Marmotton <input type="checkbox"/> Pup	2 ans <input type="checkbox"/> 2 years old
	1 an <input checked="" type="checkbox"/> Yearling	≥ 3 ans <input type="checkbox"/> ≥ 3 y

Echantillons / Samples : nbr + étiquette / label

Feces <input checked="" type="checkbox"/> <input type="checkbox"/>	Eurytic <input type="checkbox"/>
Poils / Hair <input type="checkbox"/>	Leucotic <input type="checkbox"/>
Biopsy <input type="checkbox"/> <input type="checkbox"/>	Hematocryte <input type="checkbox"/>
TV / Green tube <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Jugal <input type="checkbox"/> <input type="checkbox"/>
TR / Red tube <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Bucal <input type="checkbox"/> <input type="checkbox"/>
Frotti / Blood smear <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: _____ Htot: _____ Hematie: _____

Remarques / remarks _____

Extraction GB Stress

Action pose <input type="checkbox"/> dépose <input type="checkbox"/>	Implantation id: intra-abdo <input type="checkbox"/> ss-cut <input type="checkbox"/>	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"/>
H début/start: _____	H fin/end: _____	Comments:		

Action pose <input type="checkbox"/> dépose <input type="checkbox"/>	Implantation id: intra-abdo <input type="checkbox"/> ss-cut <input type="checkbox"/>	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"/>
H début/start: _____	H fin/end: _____	Comments:		

Action pose <input type="checkbox"/> dépose <input type="checkbox"/>	Implantation id: intra-abdo <input type="checkbox"/> ss-cut <input type="checkbox"/>	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"/>
H début/start: _____	H fin/end: _____	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: