

Marmottes Sassièrè/ Marmots Sassièrè

Date: ___/___/20___ Time: ___h___ N° fiche/sheet: _____ Opérateur/ Handling: _____ N° individu: _____ N° capture: _____

Territoire: _____ Territory	Recapture	yes <input type="checkbox"/>	Statut social	Dominant <input type="checkbox"/>
		no <input type="checkbox"/>		Sub <input type="checkbox"/>

Measures

Masse corporelle / Body mass (g) _____

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° _____			Paint
	Metal	n° _____	Oreille / ear _____	
	Plastic	n° _____	Oreille / ear _____ color _____	
	Implant	yes <input type="checkbox"/>	no <input type="checkbox"/>	

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

Echantillons / Samples : nbr + étiquette / label

Feces <input type="checkbox"/>	<input type="radio"/>	Eurytic <input type="checkbox"/>	<input type="radio"/>
Poils / Hair <input type="checkbox"/>	<input type="radio"/>	Leucotic <input type="checkbox"/>	<input type="radio"/>
Biopsy <input type="checkbox"/>	<input type="radio"/>	Hematocyte <input type="checkbox"/>	<input type="radio"/>
TV / Green tube <input type="checkbox"/>	<input type="radio"/>	Jugal <input type="checkbox"/>	<input type="radio"/>
TR / Red tube <input type="checkbox"/>	<input type="radio"/>	Bucal <input type="checkbox"/>	<input type="radio"/>
Frotti / Blood smear <input type="checkbox"/>	<input type="radio"/>	Anal <input type="checkbox"/>	<input type="radio"/>

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

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

Extraction GB <input type="checkbox"/>	Stress <input type="checkbox"/>
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Remarques / remarks

