



HEMATOLOGY SUBMISSION FORM

Print Form

CONTACT INFORMATION-Clinic/Veterinarian		PATIENT INFORMATION			
Clinic Name:		Owner:			
UW Veterinary Care Account #:		(last)		(first)	
Address:		Animal:			
City, State, Zip:		** (Name/ID)			
Phone:		Species:			
Email:		Breed:			
		DOB:	Sex:	F	FS M MC
Veterinarian:					
Phone:					
Email:					

ANIMAL/SAMPLE INFORMATION ** (Use for multiple sample submissions)

Species:	Breed:				
Animal/Specimen IDs:	DOB	Sex	DOB	Sex	
1.			5.		
2.			6.		
3.			7.		
4.			8.		

*If specimens exceed available slots please submit an excel sheet to the lab email: clinpathlab@vetmed.wisc.edu

HISTORY

Brief History:

SPECIMEN INFORMATION

Collection Date:	Time:	Routine	ASAP	STAT
Specimen type:				

TESTS

CBC W DIFF	CBC W RETIC	AV REP CBC W DIFF
CBC CNTS ONLY		
RETIC COUNT ONLY	PLT ONLY	Other: