Print Form

HEMATOLOGY SUBMISSION FORM

UW Veterinary Care
University of Wisconsin-Madison
VETERINARY MEDICAL TEACHING HOSPITAL

Clinical Pathology Laboratory
Veterinary Medical Teaching Hospital
University of Wisconsin-Madison
2015 Linden Drive
Madison, WI 53706

Phone: 608-263-9934
Fax: 608-265-5626
Hours: M-F 8:00 am-5:00 pm CST

CONTACT INFORMATION-Clinic/Veterinarian

Clinic Name: _____

UW Veterinary Care Account #: _____

Address: _____

City, State, Zip: _____

Phone: _____

Fax: _____

Email: _____

Veterinarian: _____

Phone: _____

Email: _____

PATIENT INFORMATION

Owner: _____
(last) (first)

Animal: _____
**(Name/ID)

Species: _____

Breed: _____

Age: _____ Sex: ☐ F ☐ FS ☐ M ☐ MC

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

Species: _____ Breed: _____

Animal/Specimen IDS:

1. _____	5. _____	9. _____	13. _____
2. _____	6. _____	10. _____	14. _____
3. _____	7. _____	11. _____	15. _____
4. _____	8. _____	12. _____	16. _____

*Attach additional animal/specimen identifications

HISTORY

Brief History:

SPECIMEN INFORMATION

Collection Date: _____ Time: _____ am pm ☐ 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: