## **CYTOLOGY SUBMISSION FORM**



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	PATIENT INFORMATION
Clinic Name:	Owner:
UW Veterinary Care Account #:	(last) (first)
Address:	Animal:
City, State, Zip:	(Name/ID)
Phone:	Species:
Fax:	Breed:
Email:	Age: Sex: _ F _ FS _ M _ MC
Veterinarian:	
Phone:	
Email:	
HISTORY	
Brief History (include clinical signs, duration, lesion size, and features (eg, nodule))	
Pertinent Laboratory and/or Imaging Results:	
Differential or Tentative Diagnoses:	
SF	PECIMEN INFORMATION
Collection Date:	
(Specify site and depth, eg, cutaneou FNA/Imprint FNA Site #1:	us, subcutaneous, body wall, intra-thoracic, etc)
FNA Site #2:	
FNA Site #3:	
Additional Site:	
Synovial Fluid: (Indicate joint(s))	with counts without counts
Body Fluid: (Indicate source, eg, abdominal fluid)	
CSF: Cisternal Lumbosacral	☐ Bone Marrow (provide concurrent CBC with submission)
☐ BAL:	☐ Tracheal wash
	□ Other: