



CYTOPATHOLOGY REQUEST FORM

www.specialtyvetpath.com

PH: 206-453-5691

FAX: 206-453-3309

Diana Loeffler, DVM, MS, DACVP

Jennifer G. Ward, DVM, DACVP

Date sample(s) taken: _____ Owner's name: _____

Clinic: _____ Animal's name: _____

Clinician: _____ Species: _____

Address: _____ Breed: _____

City/St/Zip: _____ Sex: _____ Age or DOB: _____

Ph/Fax: _____ Clinical diagnosis: _____

Email: _____ Previous submissions: _____

How would you like to receive results? Fax Email Both

Test requested:

Cytopathology

Site/source: _____ # slides: _____

Cytopathology/fluid analysis

Site/source: _____ # slides / containers _____

Hematology – # slides: _____ PCV/TS: _____

Bone marrow – # slides: _____

*Include current CBC report or 2 unstained blood smears

Clinical History (include lesion description, associated clinical signs, and results of any relevant laboratory tests or imaging):