

Valley Central Veterinary Referral and Emergency Center
Veterinary Clinical Pathology Laboratory

Referring Veterinarian Cytology Requisition Form

210 Fullerton Ave Whitehall, PA 18052

P-610-435-1553

F- 610-435-6378

www.vcvrec.com

Laboratory Director:
Kristin Fisher, DVM, MS

For Test Information or Results:
Phone #: (610) 435-1553

Veterinarian: _____
Clinic Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
Date Collected: _____

Owner: _____
Animal Name: _____
Species: _____
Breed: _____
Sex: _____
DOB: _____

SPECIMEN TYPE: (only one site per form and please label all slides with name, date, location)

- Aspirate Fluid Cerebrospinal Fluid Other
 Impression Smear Synovial Fluid Cisternal
 Bone Marrow Tracheal Wash Lumbar

SPECIMEN SOURCE: _____

HISTORY/CLINICAL SIGNS: _____

APPEARANCE OF MASS/FLUID: _____

FOR LAB USE ONLY:

Color-Fluid:	
Color-Supernatant:	
Turbidity-Fluid:	

Turbidity-Supernatant:	
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Specific Gravity:	
Protein mg/dl:	
Protein gm/dl:	

WBC (/ul)	
RBC (/ul)	