Hematology Test Order Form

Patient Information

Full Name

Date of Birth

Gender

Patient ID

Contact Number

Address

Test(s) Requested

- [ ] Complete Blood Count (CBC)
- [ ] ESR
- [ ] Reticulocyte Count
- [ ] Peripheral Blood Film
- [ ] Prothrombin Time (PT)
- [ ] APTT
- [ ] D-Dimer
- [ ] Serum Ferritin
- [ ] Other

If Other, Specify

Clinical Information / Reason for Test

Physician Information

Requesting Physician

Contact Number

Physician ID / License #

Signature

Date