RELIABLE DIAGNOSTIC
ISO 15189:2012 ACCREDITED LABORATORY
Committed To Quality, Consistency & Proficiency...

REQUISITION FORM FOR PERIPHERAL BLOOD SMEAR (PBS)

Date: ....

PATIENT NAME : .... AGE: .... Yrs. ...... Months

SEX: ☐ Male ☐ Female

Client's Name: ....

Referred By: .... Contact No: ....

1. PREVIOUS HISTORY / TREATMENT:

2. CLINICAL HISTORY / PROVISIONAL DIAGNOSIS:

3. Hemogram (CBC)

Hemoglobin (Hb): ____________________

RBC: ____________________

MCV : ____________________

MCH : ____________________

MCHC : ____________________

RDW - CV : ____________________

WBC : ____________________

Differential Count : ____________________

Platelets :

4. Other Laboratory / Radiology Reports :

NOTE : CBC report and patient's history is compulsory for PBS