Reticulocyte Count Template

Patient Information

Name: John Doe

Age: 34

Gender: Male

Date of Birth: 06/15/1989 **[DD/MM/YYYY]**

Patient ID: JD-20231213

Contact Information: 1234 Main St, Anytown, USA

Insurance Provider (if applicable): _____

Physician Information

Referring Physician's Name: Dr. Jane Smith

Specialty: Hematology

Contact Information: Hematology Department, City Hospital]

Physician's Notes/Requests: N/A

Specimen Information

Collection Date: 13/12/2023 **[DD/MM/YYYY]**

Collection Time: 09:15 **[HH:MM]**

Specimen Type (e.g., Blood, Bone Marrow): Blood

Collection Method (e.g., Venipuncture, Capillary): Venipuncture

Patient Conditions/Medications that may affect count:

Iron supplements

Test Requested

- [x] **Reticulocyte Count**
- [ ] **Other Hematology Tests (specify):** _____

Results

Measurement	Result	Reference Range
Reticulocyte Count (%)	2.3	0.5-2.5
Total RBC Count	4.6 million	4.5-6 million

Hematocrit (%)	40	38-50
Hemoglobin (g/dL)	3.5	13.8-17.2
Additional Measurements	N/A	N/A

Interpretation and Comments

[Add any significant findings, interpretations, or recommendations for further testing here. Include consideration of age, gender, and clinical context.]

The reticulocyte count is within normal limits. The total RBC count is slightly low, which may be associated with the patient's history of anemia. Hematocrit and Hemoglobin levels are within the normal range. Continuous monitoring and follow-up recommended

Lab Certification and Technician/Pathologist Information

Lab Certification Number: LAB-78910

Technician/Pathologist Name: Emily Zhao

Signature: 

Date: 13/12/2023 **[DD/MM/YYYY]**

Time of Report Completion: 11:30 **[HH:MM]**

Additional Notes

[Any additional observations, comments, or contextual information relevant to the test or results.]

Patient has shown improvement in RBC count since last test. Recommend continued iron supplementation and follow-up in 6 months.

Patient Consent for Testing (if applicable):

I consent to the processing of my specimen for the purpose of medical diagnosis.

Patient Signature: 

Date: 12/13/2023 **[DD/MM/YYYY]**