

# Reticulocyte Count Template

## Patient Information

Name: \_\_\_\_\_

Age: \_\_\_\_\_

Gender: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ [DD/MM/YYYY]

Patient ID: \_\_\_\_\_

Contact Information: \_\_\_\_\_

Insurance Provider (if applicable): \_\_\_\_\_

## Physician Information

Referring Physician's Name: \_\_\_\_\_

Specialty: \_\_\_\_\_

Contact Information: \_\_\_\_\_

Physician's Notes/Requests: \_\_\_\_\_

## Specimen Information

Collection Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ [DD/MM/YYYY]

Collection Time: \_\_\_\_ [HH:MM]

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

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

Patient Conditions/Medications that may affect count:

\_\_\_\_\_

## Test Requested

Reticulocyte Count

Other Hematology Tests (specify): \_\_\_\_\_

## Results

Measurement	Result	Reference Range
Reticulocyte Count (%)		
Total RBC Count		

Hematocrit (%)		
Hemoglobin (g/dL)		
Additional Measurements		

### Interpretation and Comments

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

### Lab Certification and Technician/Pathologist Information

Lab Certification Number: \_\_\_\_\_

Technician/Pathologist Name: \_\_\_\_\_

Signature:  \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ [DD/MM/YYYY]

Time of Report Completion: \_\_\_\_ [HH:MM]

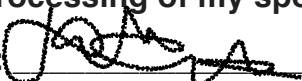
### Additional Notes

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

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### Patient Consent for Testing (if applicable):

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

Patient Signature:  \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ [DD/MM/YYYY]