

CBC Blood Test

Patient information		
Name:	Date of birth:	
Medical ID:	Gender:	
Attending physician:	Physician ID:	
Relevant medical history		
Blood draw details		
Number:	Draw date:	Draw time:
Reason for CBC blood test:		
Lab name:		
Symptoms		
<input type="checkbox"/> Bruising	<input type="checkbox"/> Bleeding	<input type="checkbox"/> Weakness
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Fever	<input type="checkbox"/> Headaches
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Joint pain	<input type="checkbox"/> Inflammation	<input type="checkbox"/> Abnormal heart rate
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> None
Other symptoms:		

Please include the normal ranges for the lab, specific to the patient's demographic.

Results

Component	Results (include units)	Normal ranges	Interpretation
Red blood cell count (Erythrocytes)			
Hemoglobin			
Hematocrit			
Erythrocyte sedimentation rate			
Red cell distribution width			
White blood cell count (Leukocytes)			
Monocyte count			
Lymphocyte count			
Neutrophil count			
Basophil count			
Eosinophil count			
Platelet count (Thrombocytes)			
Mean corpuscular volume (MCV)			
Mean corpuscular hemoglobin (MCH)			
Mean corpuscular hemoglobin concentration (MCHC)			

Additional comments & recommendations

Signed by (lab technician):

Signature:



Date:

Signed by (physician):

Signature:



Date: