INLAND EMPIRE VETERINARY IMAGING
CLINICAL PATHOLOGY SERVICE

www.ievetimaging.com

Hospital/Clinic ______________________ Veterinarian ______________________

Hosp./Clinic Phone ______________ Hosp./Vet Email ______________ Collection Date ________

Owner Name ______________________ **Animal Name** ______________________

SPECIES

- ☐ Canine
- ☐ Equine
- ☐ Feline
- ☐ Other ______________

Breed ______________

Animal Age ______________

SEX

- ☐ M
- ☐ MN
- ☐ F
- ☐ FS

- ☐ Cytology
- ☐ Fluid Analysis
- ☐ Synovial Fluid Analysis
- ☐ CBC w/ Path Review
- ☐ CSF
- ☐ Bone Marrow* *Rec'd CBC within 24 hours
- ☐ Urine Sediment/ Blood Smear Review
- ☐ Urinalysis

HISTORY/LESION DESCRIPTION (ATTACH ADDITIONAL PAGES AS NECESSARY)

Duration of Lesion/Clinical Signs ______________________

FOR MASSES

Size ______________ Shape ______________ Color ______________

Consistency ______________ Distribution ______________

Working Diagnosis ______________________

SAMPLE SITE/LOCATION — # OF SPECIMENS/SLIDES

1. ______________________ ______________
2. ______________________ ______________
3. ______________________ ______________

Additional Sites ______________________ ______________

LOCATION

21 East Mission Ave. Spokane, WA 99202 | (509) 326-7289 | pathology@ievetimaging.com