FORM F: HEMATOLOGY MONITORING
Screening Visit

PATIENT ID#: ____ ____ ____

PATIENT INITIALS: ____ ____ ____

Lab _____

Center: _____

Form completed by: _____

Date assessment completed: ___ ___/ ___ ___/ ___ ___ ___ ___

CBC	Value	COMMENTS
1. WBC x 1000/UL		
2. RBC x 1000/UL		
3. Hemoglobin G/DL		
4. Hematocrit %		
5. MCV Fl		
6. MCH pg		
7. MCHC G/DL		
8. Platelets x 1000 U/L		
9. Bands %		
10. Neutrophils %		
11. Lymphocytes %		
12. Monocytes %		
13. Eosinophils %		
14. Basophils %		
15. NRBC/100 WBC		
16. Reticulocytes %		
17. Ferritin NG/ML		
18. Hemoglobin F%		