**Imaging Referral Form**

Please fill out referral form completely

|  |  |  |
| --- | --- | --- |
| Date: |  | Owner Name: |
| DVM Name: |  |  | Owner Phone: |
| Hospital Name: |  |  | Owner Email: |
| Phone: ( ) |  |  | Owner Address: |
| Fax: ( ) |  |  | Patient Name: Weight: |
| DVM Email: |  |  | Breed: Species: |
|  |  |  | Sex: FS **□** FI **□** MN **□** MI **□**  Age:  |

**Patient's pertinent laboratory, historical and physical exam findings**

Historical Summary and Pre-existing Medical Conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous anesthetic complications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Minimum medical database requested:** CBC  Chem Screen  Coag, if biopsy requested

Please provide copies of any additional RECENT test results, if applicable:

Other blood panels  Urinalysis  CT results  MRI results 

Thoracic radiographs US results 

**Study Type**

Please contact our staff prior to referral for imaging if you have any questions regarding the imaging method of choice and/or estimates

Anatomical Region(s) to Scan:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CT Scan  MRI  Biopsy or FNA, if possible: Yes  No 

Service Requested/Goal of Study\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \*As a tertiary care facility, please note that referrals for radiation therapy can only be accepted from specialists.