

**Radiation Referral Form**

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| DVM Name: |  | Date: |
| **Specialty:** | Oncology **□** |  Internal Medicine **□** | Owner Name: |
| Surgery **□** | Neurology **□** |  Cardiology **□** | Owner Phone: |
| Dermatology **□** | Dentistry **□** |  Other\_\_\_\_\_\_\_\_\_\_\_\_ | Owner Email: |
| Hospital Name: |  |  | Owner Address: |
| Phone: ( ) |  |  | Patient Name: Weight: |
| Fax: ( ) |  |  | Breed: Species: |
| DVM Email: |  |  | Sex: FS **□** FI **□** MN **□** MI **□**  Age: |

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

Historical Summary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

**Minimum medical database requested**

Please provide copies of RECENT test results: CT **□** MRI **□** CBC **□** Chem Screen **□** T4 **□** Urinalysis **□** Thoracic radiographs **□** US results **□** Coag and CBC, if biopsy requested **□**

**Radiation Therapy**

Please provide us with all available imaging (CT, MRI, US and/or Radiographs) that have been completed for this patient.

Primary location for radiation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Additional Site (for radiation) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Study Type (Imaging)**

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 (Diagnostic) **□**  CT with immobilizer (Radiation Therapy Planning) **□**  MRI(Diagnostic) **□** Ultrasound **□**

 Biopsy or FNA, if possible: Yes **□** No **□**

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