



Veterinary Imaging Center
OF SOUTH TEXAS, P.A.

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Radiographic Referral Form

Date: _____ Referring Veterinarian: _____

Phone #: _____ Veterinary Clinic: _____

Fax #: _____ Address: _____

Patient Signalment

Owner's Name: _____ Pet's Name: _____

Species: _____ Breed: _____

Sex: _____ Age (Date of Birth): _____

Date of Radiographs: _____ Area of Interest: _____

Contrast Given? Yes No Sedation/Anesthesia given? _____

Presumptive Diagnosis: _____

Pertinent History, Clinical Findings & Laboratory Results:
