

Diagnostic Imaging Referral Form



This completed form as well as recent laboratory findings and patient records should be transmitted to VIC with radiographs or prior to patient arrival.

Date: _____

Patient Information

Patient Name: _____

Species: _____ Weight: _____

Breed: _____ Age: _____

Sex: Male Female Altered

Client Information

Name: _____

Address: _____

City/State: _____ Zip: _____

Phone: (____) _____ Cell: (____) _____

Referring Veterinarian Information

Dr.: _____

Address: _____

Practice: _____

Email: _____

Phone: (____) _____ Fax: (____) _____

Please select the examination desired below

<input type="checkbox"/> Radiographic Interpretation Arrival by: <input type="checkbox"/> Courier <input type="checkbox"/> Mail <input type="checkbox"/> Owner/Hand deliver <input type="checkbox"/> Electronic Region of interest: <input type="checkbox"/> Thorax <input type="checkbox"/> Abdomen <input type="checkbox"/> Other: _____ Date of radiographs: _____ Sedation/Anes.: _____ Contrast: _____
<input type="checkbox"/> Ultrasound* Region of interest: <input type="checkbox"/> Abdomen <input type="checkbox"/> Echocardiogram <input type="checkbox"/> Other: _____ <input type="checkbox"/> Aspirate: _____ <input type="checkbox"/> Biopsy: _____ (please include coagulation profile) * If radiographs were obtained please have them accompany the patient for the procedure.
<input type="checkbox"/> Radiographic Studies (To be obtained at VIC) Region of interest: <input type="checkbox"/> Thorax <input type="checkbox"/> Abdomen <input type="checkbox"/> Extremities/Other: _____ <input type="checkbox"/> Penn HIP <input type="checkbox"/> OFA Hips Elbows Both (please circle)
<input type="checkbox"/> Computed Tomography (CT Scan)** Region of interest: <input type="checkbox"/> Brain <input type="checkbox"/> Nasal <input type="checkbox"/> Other: _____ ** Please have recent blood analysis available due to anesthesia/contrast administration.
<input type="checkbox"/> Nuclear Scintigraphy <input type="checkbox"/> Portovenogram <input type="checkbox"/> Glomerular Filtration Rate (GFR) <input type="checkbox"/> Thyroid Scan*** <input type="checkbox"/> Other: _____ *** For Iodine (I^{131}) treatment, please use the Feline Hyperthyroid request form.

Presumptive Diagnosis: _____

Pertinent History · Clinical Findings · Laboratory Results · Special Requests
