



Case number: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_

## Veterinary Referral Form

### Referring Veterinary Information:

Referring Clinic: \_\_\_\_\_

Referring Veterinarian: \_\_\_\_\_

Tel: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

### Patient Information:

Owner Name: \_\_\_\_\_ Contact Number: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Microchip No.: \_\_\_\_\_

Species: \_\_\_\_\_ Breed: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Neutered: \_\_\_\_\_ Weight: \_\_\_\_\_

**Diagnosis & Medications:** \_\_\_\_\_

**Potential foreign bodies:** \_\_\_\_\_

**Physical Exam: CV:** \_\_\_\_\_ **RESP:** \_\_\_\_\_ **NEURO:** \_\_\_\_\_

**Previous sx including when / where:** \_\_\_\_\_

### Patient History (Please fill in block letters)

### Remarks (Please fill in block letters)

**Modality** MRI  CT  Ultrasound (area: \_\_\_\_\_)

**CT Body Areas** Head (Skull + Mid-Neck)  Thorax (Mid-neck to Liver)

Abdomen (Above Diaphragm to Pelvis)  Limb : F  H

Spine 1: C1-T2  Spine 2: T3-Tail

**MRI Body Areas** Skull / Head / Neck : Brain :  Nasal :  Neck / Thyroid / Larynx :  Orbit :

Spine : C1-T2 :  T3-L3 :  (with S2 localizer) T9-L5 :  (with S2 localizer)

L4-S2 :  T3-S2 :  ( Double Study )

**Musculoskeletal** : Brachial Plexus :  Shoulder :  Extremity :  Other :  \_\_\_\_\_

**Please choose the following option for the radiologist report :** Idexx  Vet-CT

# Sedation, general anesthesia and contrast injection are all included within the scan

**Please provide with recent blood test report for risk evaluation by referring and duty veterinarians**