



FAX THIS ORDER TO: 972.869.9916

WE HIGHLY RECOMMEND THAT YOU SUBMIT ALL RELEVANT MEDICAL RECORDS AND LAB WORK SO WE CAN BE PREPARED FOR EACH CASE.

CT REFERRAL FORM – SMALL ANIMAL

Patient Name\*: Age\*: Gender\*:

Patient Weight\*: Breed\*: Date of Request\*:

Owner's Name\*: Phone\*:

Owner's Address\*: City\*: State\*: Zip\*:

Other Authorized Party/Relationship: Phone:

Email\*:

Referring Veterinarian\*: Phone\*:

Clinic Name\*:

Address\*:

Email\*: Fax\*:

Please send any radiographs taken at your clinic for your client's appointment.

Radiographs\*: [ ] Sent digitally [ ] Sent with client [ ] None taken

Each patient should have a physical exam, CBC, chemistry panel and 3-view chest radiographs (if > 6 years old) prior to the CT exam to evaluate anesthetic risk (approximately 1.5 to 2 hours). Please send lab results and/or x-rays with this order if available. Intravenous iodinated non-ionic contrast is used on most CT studies.

Please check exam you are prescribing for this patient\*:

- [ ] CT of Skull / Nasal Passage
[ ] CT of Spine
[ ] CT of General Abdomen
[ ] CT of Thorax
[ ] CT of Elbows [ ] Left [ ] Right

Specific area of interest\*:

Working diagnosis and reason for exam\*:

Symptoms\*:

Surgical clips present\*? [ ] Yes [ ] No Foreign metal objects\*? [ ] Yes [ ] No Where?

Previous surgery\*? [ ] Yes [ ] No

Additional exam you are prescribing\*:

Veterinarian's Signature\*:

\*Required field.