AnimalImaging
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EMAIL OR FAX THIS ORDER TO:
info@animalimaging.net - (972) 869-9916
PLEASE SUBMIT ALL RELEVANT MEDICAL RECORDS AND LAB WORK SO WE CAN BE PREPARED FOR EACH CASE.

REQUEST FOR FLUOROSCOPIC EXAM – SMALL ANIMAL

If referring this case on an emergency basis, please email/fax the referral form and contact our office directly.

Patient Name*: Age*: Gender*:

Patient Weight*: Breed*: Date of submission*:

Owner's Name*: Phone*:

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

Other Authorized Party/Relationship: Phone:

Owner's Email*:

Referring Veterinarian*: Phone*:

Clinic Name*:

Email to send copy of report to*: Fax*:

Please send any radiographs or labs performed at your clinic for your client's appointment*.

Radiographs: ☐ Sent through DVM insight ☐ Emailed to info@animalimaging.net ☐ Sent with Client ☐ None taken
Current Labwork?: ☐ Yes ☐

Please check the exam that you are prescribing for this patient. Include all relevant records, labs and radiographs with each referral*.

☐ Collapsing trachea ☐ Esophagram ☐ Other _____

Please list any current medications*:

Case summary and working diagnosis*:

Symptoms/clinical signs*:

Veterinarian's signature*:

*Required field.

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