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Advanced Imaging Referral Form

Referring Veterinarian: ______________________________

Clinic / Hospital: ______________________________

Clinic Email: ______________________________

Client Name (Full): __________________________

Client Contact No: __________________________

Patient Information

Name: ______________________________________ **Sex:** ☐ M ☐ F **Sterilised:** ☐ Y ☐ N

Species: _______________ **Breed:** _____________ **Age:** _____________ **Weight:** __________________

Outpatient Service Request (Please check where applicable)

Region(s) of interest

- ☐ Brain
- ☐ Nose
- ☐ Orbit
- ☐ Auditory canals

- ☐ Craniofacial
- ☐ Neck
- ☐ Thorax
- ☐ Extremity
  (Specify limb(s) and region(s)):
  ____

- ☐ Abdomen
  ☐ Liver ☐ Kidneys ☐ Bladder ☐ Ureter(s)
  ☐ Urethra ☐ Others: ____________________
- ☐ Spine
  ☐ Cervical ☐ Thoracolumbar ☐ Lumbosacral
- ☐ Others: ________________________________

Study

☐ Plain ☐ Myelogram ☐ Contrast angiogram ☐ Intravenous pyelogram ☐ Intravenous contrast ☐ Others: ____________

Presenting problem / Tentative diagnosis

____

____

Current treatment(s) (including medications and dosages)

____

____

Case history / Physical examination findings summary

____

____

Please state any concerns regarding general anaesthesia

____

____

Laboratory results / data (check where applicable)

- ☐ Haematology
- ☐ Biochemistry
- ☐ Urinalysis
- ☐ Not done
- ☐ Biopsy Information
- ☐ Coming with owner
- ☐ Emailed / Faxed

Imaging data (check where applicable)

- ☐ Radiograph(s)
- ☐ Ultrasound report
- ☐ Coming with owner
- ☐ Emailed / Faxed
- ☐ Not done

Interpretation of Results

☐ Required (additional charges apply) ☐ Not required, image DVD will be given to client on discharge

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Signature / Date