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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

_____
**Signature / Date**