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

### RADIOLOGY PATIENT REFERRAL INFORMATION

Referral for:  **Ultrasound Referral**  
 **Radiographic Consult**

Analog:

Digital:

# images _____	Date taken: _____
# images _____	Date taken: _____
# images _____	Date taken: _____
If multiple dates, please list date and # of images	

Referring Veterinarian: \_\_\_\_\_ Clinic/Practice Name: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip Code: \_\_\_\_\_

Daytime Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Evening Telephone: (\_\_\_\_) \_\_\_\_\_ E-mail \_\_\_\_\_

Preference for Initial Communication: \_\_\_\_\_ Telephone \_\_\_\_\_ Fax \_\_\_\_\_ Both

**Client Name:** \_\_\_\_\_ **Pet Name:** \_\_\_\_\_

Canine  Feline Breed \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_

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Presenting Complaint:

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History:

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Physical Examination Findings:

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Pertinent Laboratory Results:

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Current Treatment:

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Specific Questions to Address:

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\_\_\_\_\_ Send Request Forms \_\_\_\_\_ Payment Enclosed \_\_\_\_\_ Bill Me