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| Date: |
| Clinic Name: |
| Doctor in Charge of Case: |
| Email Address for U/S report: |
| Type of Scan Requested (please circle): Abdomen/echo/double cavity/otherFor **abdomens** only, please check one:Report to be completed by Dr. Jarrett Specialist overread  |
| Patient First Name: Last name: (Please circle): Canine / Feline |
| M MN F FS Age: Breed: Weight:  |
| Reason for Ultrasound: |
|  |
| Current Medications: |
| Bloodwork findings: |
|  |
| Urinalysis findings: USG: |
| Coag times (if applicable) PT\_\_\_\_\_\_\_\_\_\_\_\_\_ PTT\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Please email to: cj@potomacmvu.com or have ready at the time of the ultrasound. By submitting this form, this veterinary practice acknowledges agreement to payment terms set forth by Potomac Mobile Veterinary Ultrasound. I understand that payment is due immediately upon completion of the ultrasound, unless previous payment arrangements have been made in advance.