SHUKSAN VETERINARY SERVICES

# Ultrasound Referral Form

Referring Clinic:_____ Veterinarian:_____

Referring Veterinarian Phone:_____

Veterinarian Email:_____

Client Last Name:_____ Client First Name:_____

Patient Name:_____ Species:_____

Breed:_____ Gender:_____ DOB:_____ Weight:_____

Chief Complaint:_____

Patient History/Clinical Signs (Include duration and severity):

_____

_____

_____

_____

_____

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_____

Physical Exam (Include TPR if known):

_____

_____

_____

Completed Diagnostics:

_____

_____

_____

_____

_____

Current Treatment Plan:

_____

_____

_____

_____

Do you feel that this patient can tolerate mild sedation?

**YES NO**

Would you like aspirates of abnormal tissues if possible and the owner consents?

**YES NO**

**ASA Risk Category:** I (healthy) II (mild to moderate disease)  III (severe systemic disease)

How soon should this patient be seen?

Same Day -  Urgent (1-2 days) -  Week (3-6 days) -  Next available (1-4 weeks).

Does this patient have any allergies or known drug reactions?

_____

_____

Comments:

_____

_____

To begin a referral case please submit this completed form via email to shuksanvet@gmail.com