



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):

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

By texting our number, you agree to receive text messages at the provided number from Shuksan Veterinary Services. Message frequency varies, and standard message and data rates may apply. You have the right to OPT-OUT receiving messages at any time. To OPT-OUT, reply "STOP" to any text message you receive from us. Reply HELP for assistance.