Ultrasound Referral Form

Revised September 2019

Referring Clinic: ________________________ Veterinarian: ___________________

Referring Veterinarian Phone: ____

Veterinarian Email: ____

Client Last Name: ________________Client First Name: ___________________________

Client Address: ____

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Client Phone: ___________________________ Client e-mail______________________

Patient Name: ____________________________ Species __________________________

Breed ______________________Gender__________ DOB_______________________

Reason For Study/Pertinent Lab Findings:

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History for Radiologist:

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Other Underlying Illnesses:

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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)

Class IV and V risk patients should be admitted to the closest referral hospital for imaging.

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:

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