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):

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_____

Completed Diagnostics:

_____

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_____

Current Treatment Plan:

_____

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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)

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