IMAGING REQUEST & REFERRAL FORM

Collin County VETERINARY IMAGING Center

Clinic Name: _____

Referring Veterinarian: _____

Date: _____ Clinic phone: _____

Owner Name: First_____ Last_____

Phone Number: _____Secondary Phone Number_____

Owner Address: _____

Patient Name: _____ Age: _____ Breed: _____

Wt. _____lb./kg. (circle one) Sex: Neutered Male / Spayed Female / Male / Female (circle one)

Patient History:

Ultrasound: ___ Abdominal ___ Thoracic ___ Echocardiography (heart only)

Computed Tomography: ___ Head and neck ___ Abdomen/Pelvis ___ Thorax ___ Spine ___ Extremities

Radiographic Consult: ___ Email images ___ Client providing images

STAT (additional fee): ___

For a complete assessment, please send any recently performed imaging including radiographs with the patient regardless of desire for radiographic consultation. For CT imaging with contrast please include recent (within 6 months) blood work including renal profile. If biopsy samples are requested, please send a current (within 24 hours) clotting profile to include a Prothrombin Time as well as a Partial Thromboplastin Time result. Preliminary ultrasound results should be available the same day and radiology consultation for both ultrasound and CT should be available within 24 hours.

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