



### Diagnostic ONLY Ultrasound Referral

**Diagnostic ONLY:** Your patient will be admitted for an abdominal or cardiac ultrasound. All reports will be returned to you for communication, medical and/or surgical management with your client.

Date:

#### Client/Patient Information

Owner: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Cell/Ph #: \_\_\_\_\_

Email: \_\_\_\_\_

Pet name: \_\_\_\_\_ Species: \_\_\_\_\_

DOB: \_\_\_\_\_ Sex: \_\_\_\_\_

Spay/Neuter: \_\_\_\_\_

Breed: \_\_\_\_\_ Wt: \_\_\_\_\_

#### Referring Veterinarian Information

Hospital: \_\_\_\_\_

Veterinarian: \_\_\_\_\_

Phone:  \_\_\_\_\_

Email:  \_\_\_\_\_  
(please indicate preferred contact method)

Status:

Urgent  Non Urgent  Emergency

Core Vaccine Status: (DA2PP and Rabies)

Current  Unknown

#### History

(please include presenting complaints, previous and current medical therapies and duration of problem)

Required Oral Sedation Prescription: Trazodone 6-8 mg/kg and Gabapentin 10-20 mg/kg to be given by mouth the evening prior to the ultrasound, and again, 12 hours later and approximately 3 hours prior to the appointment.

Oral Sedation Sent Home                      yes

Bloodwork done?                                yes                                 no

X-rays? (Please attach)                        yes                                 no

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