6675 E. Waterloo Rd.
Edmond, OK 73034

Small Animal Referral Form

(405) 359-5002
Fax: (405) 359-2869

Referral Hospital: __________________________ **Primary Doctor:** ________________________

Hospital Phone: ______________________

Hospital Fax or Email (circle to receive MRI report): ____

OWNER NAME: ______________________________ Client Phone: ____________________________

Client Address: ______________________________ Secondary Phone: ________________________

City: _________________ State: _____ Zip: _______

PATIENT NAME: _____________________________ Canine ☐ Feline ☐ Other: ___________

Male ☐ Female ☐ Spayed/Neutered? ☐

Breed: ________________ Age: _______ Weight: ______ lb ☐ kg ☐ **Aggressive?** Yes ☐ No ☐

<u>Please select from the following options</u>:**

Brain ☐ Cervical Spine ☐ Thoracic Spine ☐ Lumbar & Sacrum ☐

Other (specify) ☐ ______________________

****Additional sites may be needed depending on patient size**

History/Clinical Signs:____

____

____

Preliminary Diagnosis: ____

All Current Medications: ____

____

Please include copies of any recent sedation/anesthetic events along with current bloodwork.

Has this patient ever had an adverse drug reaction? Yes ☐ No ☐If yes, please attach explanation.

Permission for General Anesthesia? Yes ☐ No ☐

CPR directive: Authorization to perform resuscitation measures if required? Yes ☐ No ☐

Would you like a copy of the images on a CD? Yes ☐ No ☐ **Same Day Read? Yes ☐ No ☐**

REFERRAL POLICY: Patients referred by veterinarians will receive services related to the presenting problem only. Clients are requested to return to their referring veterinarian for all other services.
PERMISSION TO SCAN is granted by the signer below as representative of the referring hospital, or as the patient's owner.

Signature: ______________________________________ **Date:** ______________