CAT THYROID CENTER

REFERRAL FORM

Please email this form with all lab/diagnostic values to:
info@catthyroid.com

CLIENT INFORMATION

NAME:

EMAIL:

PHONE:

PATIENT INFORMATION

NAME: **AGE:** **SEX:**

DATE OF ORIGINAL DIAGNOSIS:
(MONTH,DAY,YEAR)

DO NOT LEAVE BLANK

Methimazole/Felimazole dose/frequency and start date:

Is there any evidence of cardio abnormalities/ heart murmur?
(PLEASE LIST GRADE OF MURMUR OR SPECIFIC ABNORMALITY)

Is patient currently on a y/d diet? YES NO

Is patient currently up to date on Rabies vaccine? YES NO

Is patient currently up to date on FVRCP vaccine? YES NO

Is patient free of infectious illness or disease? YES NO

How is the patient's temperament? Calm Fractious

Has the patient ever required sedation to handle? YES NO
(Not including advanced diagnostics or surgery)

Does the patient have a tendency to urinate and defecate when being handled? YES NO

DIAGNOSTICS REQUIRED WITHIN 90 DAYS OF TREATMENT DATE

- Complete Blood Count
- Complete chemistry/electrolyte panel
- Urinalysis with sediment exam
- Total T4
- Free T4 and or T3 --- Recommended, but optional
- Radiographs - whole cat
  (2 views: Ventral/Dorsal and Lateral)

PLEASE EMAIL ALL DIAGNOSTICS, INCLUDING THE BLOOD WORK FROM THE ORIGINAL DATE OF DIAGNOSIS LISTED ABOVE TO : INFO@CATTHYROID.COM

VET INFORMATION

NAME: **EMAIL:**

CLINIC: **PHONE:**