FRESNO VETERINARY SPECIALTY & EMERGENCY CENTER

CT REFERRAL FORM

Please fax completed form to: 559-451-0808

or send with your client

Date: _____

Referring Veterinarian: _____

Referring Hospital: _____

Referring Veterinarian contact phone: _____

Patient Information

Patient Name: _____ Last Name: _____

Client Name: _____ Phone Number:_____

Species: __canine /_feline___ Age: _____ Sex: _____N/S Breed: _____

Case Information

Tentative Diagnosis: _____

_____

Additional Information (anesthesia concerns):_____

_____

Requesting CT of:

____Abdomen ____Brain ____Bullae ____Nasal ____Orbits ____Mass ____Throax

____Spine/Specify: _____ ____Extremity/Specify:_____ ____Other: _____

Would you like the CT read by our Radiologist at Pet Rays? YES NO If no, the DVD will be sent with your client for you to read

Would you like our attending Veterinarian to discuss the results of the CT with the owner? YES NO

Requests for Patient Transfer Post-Scan (Select one)

____ Referring Veterinarian ____ Home ____ Other:_____

Has any labwork been performed in the last 30 days? YES NO If yes, please send with client

Have radiographs been taken? YES NO If yes, please send with client

Thank you for your referral! Please have your client bring the medical record, labwork, and radiographs, if applicable. If selected, we will be sending you the Radiologist Report from Pet Rays. Please look for this report in your fax or email.