6675 E. Waterloo Rd.
Edmond, OK 73034

Oakridge

Small Animal Referral Form

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

Referral Hospital: _____ **Primary Doctor:** _____

Hospital Phone: _____ Direct Phone (emergency only): _____

Hospital Email (for MRI report): _____

Specialist referring case to, if applicable: _____

OWNER NAME: _____ Client Phone: _____

Client Address: _____ Secondary Phone: _____

City: _____ State: _____ Zip: _____ Email: _____

PATIENT NAME: _____ Canine ☐ Feline ☐ Other: _____

Male ☐ Female ☐ Spayed/Neutered? ☐

Breed: _____ Age: _____ Weight: _____ lb ☐ kg ☐ **Aggressive?** Yes ☐ No ☐

Please select from the following options:
Brain ☐ C1- T2 ☐ T3-L3 ☐ L3-Sacrum ☐ Other (specify) ☐ _____

¤CSF taps are NOT offered¤

History/Clinical Signs: _____

_____

_____

Localization: _____

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 the study emailed to you? Yes ☐ No ☐ STAT Read? Yes ☐ No ☐

MRI Report written by: Radiologist ☐ Neurologist (Dr. Levine) ☐

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:** _____