Oakridge Veterinary Imaging, P.L.L.C.
6675 E. Waterloo Road Edmond, OK 73034
(405) 341-9350 Fax (405) 359-2869

EQUINE PATIENT REFERRAL:

DATE: / / **OVI use only: Patient ID** _____

REFERRING HOSPITAL _____ **Primary Vet** _____

Hospital Phone _____ Hospital Fax _____

Would you like a copy of the MR on CD or film? (extra charge) Yes_____ No_____

OWNER NAME _____ **PATIENT NAME** _____

Client Phone _____ Secondary Phone _____

Client Address _____ City _____ State ____ Zip _____

Use _____ Breed _____ Age____ M___ F___ G___

Date First Lame: _____

History (duration of symptoms, onset): _____

Lameness (grade 1-5, response to flexion and hoof testers, list all limbs with abnormalities): _____

Clinical Signs (heat, swelling, effusion): _____

Diagnostic Anesthesia (block and percent improvement, does lameness switch to contralateral limb):

Radiographic/Ultrasound/Scintigraphy Findings: _____

Clinical Diagnosis: _____

Previous Therapy (medication, response, duration): _____

Permission for General Anesthesia? Yes____No____

Referral Policy: Patients referred by veterinarians will receive services related to the presenting problem only. Clients are requested to return to their regular veterinarian for all other work.

PERMISSION TO SCAN is granted by the signer below as representative of the referring hospital or as the patient's owner.

Signature: _____ Date: _____