Imaging Referral Form for PetCure Oncology at VRIC

Date:	Owner Name:
DVM Name:	Owner Phone:
Hospital Name:	Owner Email:
Phone: ( )	Owner Address:
Fax: ( )	Patient Name: Weight:
DVM Email:	Breed: Species:
	Sex: FS □ FI □ MN □ MI □ Age:

Patient's pertinent laboratory, historical and physical exam findings

Historical Summary _____

_____

_____

Current Medications: _____

Previous anesthetic complications: _____

Minimum medical database requested

Please provide copies of RECENT test results.

CBC □ Chem Screen □ T4 □ Urinalysis □

Thoracic radiographs □ US results □ Coag and CBC, if biopsy requested □

Study Type

Please contact our staff prior to referral for imaging if you have any questions regarding the imaging method of choice and/or estimates

Anatomical Region(s) to Scan: _____

CT Scan □ MRI □ US □ Biopsy or FNA, if possible □

Service Requested/Goal of Study*: _____

**As a tertiary care facility, please note that referrals for radiation therapy can only be accepted from specialists.*