DESERT VETERINARY MEDICAL SPECIALISTS

The experts in compassionate care.

OUTPATIENT RADIOLOGY SERVICES REFERRAL FORM

Referring Veterinarian's Name:		Date:
Hospital Name:		
Street Address:		
City:	State:	Zip:
Phone:	Fax:	
E-mail:		
Client Name:		
Home Phone:	Cell/Other:	
Patient's Name:	Species:	
Breed:	Date of Birth:	
Sex: ☐ M ☐ F	Altered: ☐ Yes ☐ No	
Medical History/ Physical Exam Findings:		

Radiographs

- ☐ Thorax
- ☐ Abdomen
- ☐ Neck
- ☐ Spine
  - ☐ Cervical spine
  - ☐ C/T spine
  - ☐ Thoracic spine
  - ☐ T/L spine
  - ☐ Lumbar spine
  - ☐ Lumbosacral spine
  - ☐ Full spine
- ☐ Forelimb
  - ☐ Left ☐ Right
  - ☐ Scapula
  - ☐ Shoulder
  - ☐ Humerus
  - ☐ Elbow
  - ☐ Antebrachium
  - ☐ Carpus
  - ☐ Forepaw
- ☐ Hindlimb
  - ☐ Left ☐ Right
  - ☐ Pelvis
  - ☐ Femur
  - ☐ Stifle
  - ☐ Tibia
  - ☐ Tarsus
  - ☐ Hindpaw

Please send my report via ☐ Fax ☐ Email

Ultrasound

- ☐ Abdomen
- ☐ Thorax (non-cardiac)
- ☐ Musculoskeletal
  Body part _____
- ☐ Neck

CT

- ☐ Nasal/Head
- ☐ Thorax
- ☐ Abdomen
- ☐ Neck/Cervical spine
- ☐ Thorax/Cervical spine
- ☐ Lumbosacral spine
- ☐ Musculoskeletal
  Body part _____

For patients referred directly to DVMS for radiograph studies or procedures, please read and initial the following:

I have performed a complete physical exam and found this patient stable and healthy enough for sedation or anesthesia necessary to complete the requested studies. Animals at increased risk due to illness will be evaluated by a specialist at DVMS or Blue Pearl Veterinary Partners, LLP.

_____

Referring doctor's initials

Please attach additional pages including medical records and original lab reports directly relating to this medical condition. Please send pertinent radiographs or other diagnostic images. Charges will be assessed on a standard per study basis. Please call our doctor if there is any immediate information you need to relay about this case. Thank you for the opportunity to participate in the treatment of this patient.

01/16

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