Dr. Vet د. فت

Animal Hospital المستشفى البيطري المتكامل

ULTRASOUND REFERRAL FORM

Please have the referring Vet fill up the form and send it by email to (imagiology@drvet.ae) prior to the appointment date/time

CLINIC INFORMATION

Date: _____

Referring Veterinarian: _____ Referring Hospital: _____

Hospital Phone Number: _____

How would you like to be informed of the results?

❑ Fax _____ ❑ E-mail _____ ❑ Other _____

Client Information:

Client Name: _____ Contact Phone Number: _____

Patient Information:

Pet Name: _____ ❑ Dog ❑ Cat Breed: _____ Microchipped: ❑ Yes ❑ No

Sex: ❑ FS ❑ MN ❑ F ❑ M Age/D.O.B: _____ Patient wt: _____ ❑ Kgs. ❑ lbs.

Reason for referral

Appointment is on Date: Time:	The patient will come with ❑ Owner ❑ Clinic Employee ❑ Other

Documents: _____

X-rays: _____

Reason for referral: _____

Region that shall be scanned:

Spinal Cord

- ❑ Uninary Bladder
- ❑ Kidneys
- ❑ Pregnancy
- ❑ C1 - 5
- ❑ Abdomen
- ❑ Thorax
- ❑ Echo Cardiography

Did this patient have any side-adverse effect on anasesthetics in the past? ❑ Yes ❑ No
If yes, please provide details:

_____

Special Request: _____

_____

_____

_____

Current medication and/or supplements:

_____

_____

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