Dr. Vet Animal Hospital
د. فت المستشفى البيطري المتكامل

X-RAY 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:

____

____

Current medication and/or supplements:

____

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

Special Request:

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