Patient Referral Form

(Please check desired services)

❑ **Surgery Consultation**
❑ **Outpatient CT**

REFERRING VETERINARIAN INFORMATION

Date:	
Doctor:	Hospital:
Email*:	Phone:

CLIENT INFORMATION

Name:	
Address:	City/State/Zip:
Home phone:	Work phone:

PATIENT INFORMATION

Name: Species ❑ Canine ❑ Feline

Breed: Color: DOB: Weight:

Gender: ❑ Male ❑ Male-neutered ❑ Female ❑ Female-spayed

Vaccination status: ❑ Current ❑ Unknown ❑ Not current (clarify):

Previous history of medical problems:

Reason for referral :

Outpatient CT region of interest :

IV Contrast: YES NO

Tentative diagnosis:

Please email pertinent medical records/lab result/radiographs

*CT results will be sent from radiologist to referring doctors via email.

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RADIOLOGY: Anthony J. Fischetti DVM, MS, DACVR | **ADMINISTRATOR:** Elizabeth Corradi, PMP

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