Outpatient CT and US Services Request Form
Fax: 01275 836146

Referring vet name:

Practice Name:

Address: Postcode:

Email: Contact Telephone:

Client name:

Address: Postcode:

Telephone: Mobile:

Email Address:

Animal name:

Species: Breed:

Sex: Age: Weight:

Insurance Company: Policy Number:

Reason for referral request:

Anatomic region(s) to be scanned:

Modality*: CT US *delete as appropriate

History:

Clinical question to be answered:

Lab results and imaging:
Blood work from the within the last month is required for all patients undergoing sedation or general anaesthesia. Please include the results of any relevant imaging studies here.

Please delete as appropriate:

Is the patient safe to receive contrast: *Yes* *No*

Is the patient safe for sedation or anasthesia: *Yes* *No*

Orthopaedics: *Left* *Right* *Both*

Spines: *C1-C5* *C6-T2* *T3-L3* *L4-tail*

NB: Myelography, arthrography and sampling are not performed on an outpatient basis.

All results are reported to the referring veterinary surgeon by email. If you wish for a Referral Clinician to discuss findings with the client, please arrange a full referral.

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