MEDVET
MEDICAL & CANCER CENTERS FOR PETS

Radioactive Iodine Treatment Referral Form

Referral Partner:	**Practice:**
Address:	City/State/Zip:
Phone:	Fax:
E-mail:	

Client:	**Patient:**
Address:	Breed/Color:
City/State/Zip:	Age/Sex:
Phone:	
E-mail:	

Clinical Data at Diagnosis of Hyperthyroidism	**Clinical Data Post Methimazole Trial**
Date:	Date:
Total T4:	Total T4:
	Methimazole Dose: Treatment Duration:
Weight:	Weight:
Appetite (please circle): Voracious Moderate Poor	Appetite (please circle): Voracious Moderate Poor
BUN:	BUN:
Creatinine:	Creatinine:
Phosphorus:	Phosphorus:
Urine Specific Gravity:	Urine Specific Gravity:

AAHA ACCREDITED REFERRAL Practice of the Year 1st Place 2014

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