MEDVET
Leading Specialty Healthcare for Pets

Outpatient Ultrasound Referral Form

Date: _____

Referral Partner Information

Referring Veterinarian: _____ **Clinic/Practice Name:** _____

Phone: (_____) _____ **Fax:** (_____) _____ **Email:** _____

Patient Information

Client Name: _____ **Phone:** (_____) _____

Patient Name: _____ ☐ **Canine** ☐ **Feline** ☐ **Other:** _____

Breed: _____ **Sex:** ☐ M ☐ MN ☐ F ☐ FS **Age:** _____

Radiographs Submitted: ☐ Yes ☐ No Digital: ☐ Sent to DICOM Server ☐ CD Analog: ☐ Mailed in ☐ Sent with Owner

Referral Practice

☐ MedVet Chicago
☐ MedVet Cincinnati
☐ MedVet Columbus
☐ MedVet Indianapolis
☐ MedVet Dayton
☐ MedVet Toledo

Study Information

☐ Abdomen
☐ Thorax
☐ Neck
☐ Other: _____

Reason for Referral/Primary Complaint:

_____

_____

_____

_____

Clinical Exam/Pertinent Labwork Findings/Working Diagnosis:

_____

_____

_____

_____

Specific Questions to be Addressed:

_____

_____

_____

_____

The radiologist will contact the referral partner following the ultrasound exam to review the results. If there are any questions prior to the appointment date, please contact the radiology department.

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Our Locations:

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