MEDVET
Leading Specialty Healthcare for Pets

Radioactive Iodine Treatment Referral Form

Date: __________

Referral Partner Information

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

Phone: (______) ______________

Patient Information

Client Name: ______________________ **Phone:** (______) ______________________

Patient Name: ______________________ ☐ **Feline**

Breed: ______________________ **Sex:** ☐ M ☐ MN ☐ F ☐ FS **Age:** __________

Referral Practice

☐ MedVet Cincinnati ☐ MedVet Columbus

Clinical Data at Diagnosis of Hyperthyroidism:

Date: ______________________

Weight: ______________________

Total T4: ______________________

Appetite: ☐ Voracious ☐ Moderate ☐ Poor

BUN: ______________________

Creatinine: ______________________

Phosphorus: ______________________

Urine Specific Gravity: ______________________

(if available)

Clinic Data Post Methimazole Trial:

Date: ______________________

Weight: ______________________

Total T4: ______________________

Methimazole Dose:

Treatment Duration:

Route: ☐ Oral ☐ Transdermal

Appetite: ☐ Voracious ☐ Moderate ☐ Poor

BUN: ______________________

Creatinine: ______________________

Phosphorus: ______________________

Urine Specific Gravity: ______________________

(if available)

Our Locations:

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