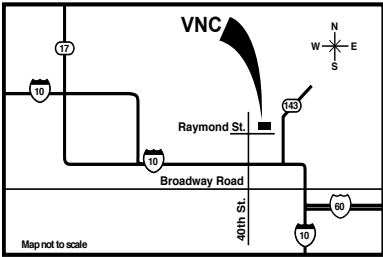


Non-Neurological CT/MR Imaging Referral Form

*This form and special pricing are for non-neurological cases only. Please contact us if you have questions.
For the most current version, please print copies or submit online from our website: www.vetneuro.com*

PHONE (602) 437-1488
FAX (602) 437-5425
EMAIL vncmail@vetneuro.com



ADDRESS 4202 East Raymond Street
Phoenix, Arizona 85040-1935

OWNER INFORMATION:

Name: _____
Telephone: _____ (work): _____
Address: _____ E-Mail: _____
City: _____ State: _____ Zip Code: _____

PATIENT INFORMATION:

Name: _____
Species: _____ Breed: _____ Age: _____ Sex: _____

REFERRING VETERINARIAN INFORMATION:

Name: _____ Hospital: _____
Telephone: _____ Fax: _____
Address: _____ Email: _____
City: _____ State: _____ Zip Code: _____

MEDICAL HISTORY:

- A. Tentative Diagnosis: _____
- B. History and Clinical Findings: _____
- C. List any known metal in patient (IM pins, plates, etc.) _____
- D. Attach copy of current CBC, Chemistry Profile, UA (within past 10 days)

IMAGING INFORMATION:

- A. Type of Study: CT MRI
- B. Area of Study:

Abdomen	<input type="checkbox"/>	Bone (specify)	<input type="checkbox"/>	_____
Thorax	<input type="checkbox"/>	Joint (specify)	<input type="checkbox"/>	_____
Adrenals/Pituitary	<input type="checkbox"/>	Other (specify)	<input type="checkbox"/>	_____
Nose/Sinuses	<input type="checkbox"/>			
- C. Known Anesthetic Risks:

Cardiac	<input type="checkbox"/>	CNS	<input type="checkbox"/>
Pulmonary	<input type="checkbox"/>	Metabolic	<input type="checkbox"/>
- D. Drug Sensitivities/Allergies: _____
- E. Previous Imaging Studies: Date: _____ Location: _____

Unless otherwise requested, imaging interpretation will be performed by:

Jaime Sage, D.V.M., M.S., Diplomate, ACVR
Veterinary Imaging Consultant (Specializing in MRI)

Permission to send imaging to Dr. Sage?

Yes

NOTE: A CD-Rom of the study will be delivered to the referring veterinarian

Veterinarian Signature

Date