

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*

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Owner Information:

Name: _____
Telephone: _____ (work): _____
Address: _____ Email: _____
City: _____ State: _____ Zip Code: _____

PHONE (602) 437-1488

FAX (602) 437-5425

EMAIL vncmail@vetneuro.com

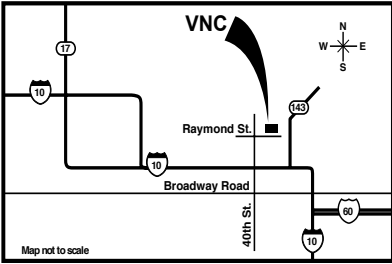
WEBSITE www.vetneuro.com

Patient Information:

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

Referring Veterinarian Information:

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



ADDRESS 4202 East Raymond Street
Phoenix, AZ 85040-1935

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	<input type="checkbox"/>	MRI	<input type="checkbox"/>
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)
www.mrivets.co

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