



San Francisco
Veterinary Specialists

SFVS CT REFERRAL FORM

(for use by referring veterinarians only)

FAX NUMBER: (415) 401-9201

DATE/TIME: _____

REQUESTING CT OF:

- | | |
|----------------------------------|---|
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> Mass |
| <input type="checkbox"/> Brain | <input type="checkbox"/> Thorax |
| <input type="checkbox"/> Bullae | <input type="checkbox"/> Spine / Specify: _____ |
| <input type="checkbox"/> Nasal | <input type="checkbox"/> Extremity / Specify: _____ |
| <input type="checkbox"/> Orbits | <input type="checkbox"/> Other / Specify: _____ |

(Check One)

- With Sedation With Anesthesia With Anesthesia and Contrast

PATIENT INFORMATION:

Pet Name: _____ Age: _____ Weight: _____

Breed: _____ Sex: M F Spayed/Neutered: Y N

Tentative Diagnosis: _____

Pertinent History: _____

Pertinent Clinical Exam Findings: _____

Pertinent Clinical Pathology Findings: _____

Laboratory Work Included: _____

Radiographs Taken/Included: _____

Client Will Bring? Yes/No

Treatment Instituted: _____

Fluids (type/amount/additives/route/rate): _____

Current Medications (drug/dose/route/time given): _____

(please complete the following page)

PATIENT INFORMATION, CONTINUED:

Known Allergies: _____

Requests for Patient Transfer Post-Scan (Check One):

Referring Veterinarian Home Other: _____

Special Requests (Dos and Don'ts): _____

CLIENT INFORMATION:

Client Name: _____
Address: _____
City/State/ZIP: _____
Main Phone: _____ Alternate Phone: _____

REFERRING VETERINARY INFORMATION:

Name: _____
Clinic/Hospital: _____
Phone: _____ Fax: _____
Best Time to Reach: _____

X Veterinary Signature: _____