# Ultrasound Referral Form

Return Fax to Case Veterinary Hospital (912) 351-5910
Hospital Phone (912) 352-3081

Referring Veterinarian:_______________________________________________

Hospital:_________________________ Phone:_____________________

Fax: _________________________ Date Exam Req:___________________

Client Name:_____________________________________________________

Phone Number:_________________________

Pet's Name:____________________________ Age:_________________

Breed: _______________________________ Sex:_________________

Presenting Complaint/History:_________________________________________

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

Current/Recent Medications:__________________________________________

_______________________________________________________________

Lab Results/Tests Pending:___________________________________________
(Please attach copy of results if possible)
Radiographic Findings:______________________________________________
(Please send radiographs with client for best case management)
Diagnosis or Rule-Outs:______________________________________________

Ultrasound Requested:_______________________________________________

Additional Tests requested (sterile urinalysis, biopsy, fluid analysis, etc.)___________

_______________________________________________________________

Is anesthesia/sedation possible if needed (or indicate if you know it will be necessary). Also please note any limitations or previous problems with anesthesia:_____________

_______________________________________________________________

Ultrasounds are scheduled according to availability for the date requested. Additional tests may require pre-anesthetic bloodwork including clotting profiles, SAP, CBC, etc.

**Please advise your clients that we do not accept checks**