



# Arizona Veterinary Imaging, PLLC

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## Radiology Services Referral Form

**Referring Veterinarian's Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Hospital Name:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Phone:** ( ) \_\_\_\_\_ **FAX:** ( ) \_\_\_\_\_

**E-mail:** \_\_\_\_\_

**Client Name:** \_\_\_\_\_

**Home Phone:** ( ) \_\_\_\_\_ **Cell/Other:** ( ) \_\_\_\_\_

**Patient's Name:** \_\_\_\_\_ **Species:** \_\_\_\_\_

**Breed:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Sex:** \_\_\_\_\_ **Altered?**  Y  N

**Medical History:** \_\_\_\_\_

**Physical Examination:** \_\_\_\_\_

Radiographs		Ultrasound	CT
<input type="checkbox"/> Study by AVI <input type="checkbox"/> Interpretation Number of views submitted _____  <b>Thorax</b> <input type="checkbox"/> 2 view standard <input type="checkbox"/> 3 view Met Check <input type="checkbox"/> Neck <input type="checkbox"/> Esophagram <input type="checkbox"/> Other _____  <b>Abdomen</b> <input type="checkbox"/> Survey Number of views: _____ <input type="checkbox"/> Upper GI Study <input type="checkbox"/> Cystogram <input type="checkbox"/> IV Pyelogram <input type="checkbox"/> Other _____  <b>Spine</b> <input type="checkbox"/> Cervical Spine <input type="checkbox"/> C/T Spine <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> T/L Spine <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Lumbosacral Spine <input type="checkbox"/> Full Spine	<b>Orthopedic</b> <input type="checkbox"/> Left <input type="checkbox"/> Right  <b>Forelimb</b> <input type="checkbox"/> Scapula <input type="checkbox"/> Shoulder <input type="checkbox"/> Humerus <input type="checkbox"/> Elbow <input type="checkbox"/> Antebranchium <input type="checkbox"/> Carpus <input type="checkbox"/> Forepaw  <b>Hindlimbs</b> <input type="checkbox"/> Pelvis <input type="checkbox"/> Femur <input type="checkbox"/> Stifle <input type="checkbox"/> Tibia <input type="checkbox"/> Tarsus <input type="checkbox"/> Hindpaw	<input type="checkbox"/> Outpatient <input type="checkbox"/> Interpretation  <input type="checkbox"/> Abdomen <input type="checkbox"/> Portosystemic Shunt <input type="checkbox"/> Non-Cardiac Thoracic  <input type="checkbox"/> Thyroid/Neck: _____ <input type="checkbox"/> Musculoskeletal _____  <input type="checkbox"/> US guided FNA <input type="checkbox"/> US guided Biopsies <input type="checkbox"/> US-guided Palliative Centesis	<input type="checkbox"/> Study by AVI <input type="checkbox"/> Interpretation  <input type="checkbox"/> Nasal <input type="checkbox"/> Bulla <input type="checkbox"/> Brain <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Thorax <input type="checkbox"/> Abdomen <input type="checkbox"/> Orthopedic _____
		<b>Nuclear Medicine</b> <input type="checkbox"/> GFR Scan <input type="checkbox"/> Regional Bone Scan <input type="checkbox"/> Body Part: _____ <input type="checkbox"/> Whole Body Bone Scan <input type="checkbox"/> Thyroid Scan <input type="checkbox"/> Portosystemic Shunt	<b>MRI</b> <input type="checkbox"/> MRI Interpretation  <b>Please send my report via</b> <input type="checkbox"/> Fax <input type="checkbox"/> E-mail
<b>For patients referred directly to AVI for radiographs studies or procedures, please read and initial the following:</b>  I have performed a complete physical exam and found this patient stable and healthy enough for sedation or anesthesia necessary to complete the requested studies. Animals at increased risk due to illness will be evaluated by a specialist at Arizona Veterinary Internal Medicine or the EAC. _____ (Referring Doctors Initials)			

Please attach additional pages including medical records and original lab reports directly relating to this medical condition. Please send pertinent radiographs or other diagnostic images. Charges will be assessed on a standard per study basis. Please call our doctor if there is any immediate information you need to relay about this case. Thank you for the opportunity to participate in the treatment of this patient.