

# Ultrasound Referral



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**sackvilleanimalhospital.ca**

## HOSPITAL INFORMATION

Referring Hospital: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Referring Veterinarian: \_\_\_\_\_

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ Species: \_\_\_\_\_

Breed: \_\_\_\_\_ DOB: \_\_\_\_\_

Sex: \_\_\_\_\_ Color: \_\_\_\_\_

Referral Service:

- Abdominal Ultrasound  U/S Assisted Liver Core Biopsy  
 Abdominal Ultrasound with Biopsy/FNA  Other: \_\_\_\_\_

## CLIENT INFORMATION

Client Name: \_\_\_\_\_ Spouse/Add'l Persons: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

- \*Please fax or e-mail referral form **along with a brief case summary** and recent medical notes, including any diagnostics pertinent to the history. Please review your referral package for specific information, including indications, preparatory information, etc, to pass along to the client in preparation for their visit. We will contact them to arrange their appointment time directly, unless otherwise arranged through you.
- Please inform clients that their pet will have their abdomen shaved and possibly given a sedative prior to ultrasound.
- All patients require a 12 hour fast, and preferably a full bladder.

Referring Veterinarian Signature: \_\_\_\_\_

(Electronic if completed on-line or signed if scanned/faxed)