**AUBURN ANIMAL HOSPITAL CT REFERRAL FORM**

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 **Please fax completed form to 661-872-6601**

 **or send with your client**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Referring Veterinary Contact Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Veterinary E-mail address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Patient Information**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Breed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Species: \_\_\_\_canine \_\_\_\_feline Age: \_\_\_\_\_\_ Sex: M or F Spay/Neutered Y or N

Case Information

Tentative Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional Information (anesthesia concerns): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Requesting CT of:

\_\_\_\_\_Abdomen \_\_\_Brain \_\_\_Bullae \_\_\_Nasal \_\_\_Orbits \_\_\_Mass \_\_\_Thorax

Spine/Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Extremity/Specify: \_\_\_\_\_\_\_\_\_\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your CT will be read by our Radiologist at VetRad. The Radiologist report will be emailed to you when received. The DVD will be sent with the client for you to read.

Would you like our attending Veterinarian to discuss the results of the CT with the owner? Yes or No

Request for Patient Transfer Post-Scan (Select One):

\_\_\_\_Referring Veterinarian \_\_\_\_\_Home \_\_\_\_Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has any lab work been performed in the last 30 days? Yes No If yes, please send with client

Have radiographs been taken? Yes No If yes, please send with client

Thank you for your referral! Please have the client bring the medical record, labwork, and radiographs if applicable. If selected, we will be sending you the Radiologist report. Please look for this report in your email or fax.

Auburn Animal Hospital 3713 Auburn St Bakersfield, Ca 93306 661-872-0363 vethospitalbakersfield.com