Animal Imaging
Veterinary Radiology Specialists

EMAIL OR FAX THIS REFERRAL TO:
info@animalimaging.net – (972) 869-9916

Please submit all relevant medical records and lab work so we can be fully prepared for each case

FLUOROSCOPY REFERRAL FORM – SMALL ANIMAL

Patient Name*: Age*: Gender*:

Patient Weight*: Breed*: Date of submission*:

Owner's Name*: Phone*:

Owner's Address*: City*: State*: Zip*:

Other Authorized Party/Relationship: Phone:

Owner's Email*:

Referring Veterinarian*: **Phone*:**

Clinic Name*:

Email to send copy of report to*: **Fax*:**

Please send any radiographs or labs performed at your clinic for your client's appointment*.

Radiographs: ☐ Sent through DVM insight ☐ Emailed to info@animalimaging.net ☐ Sent with Client ☐ None taken

Current Labwork?: ☐ Yes (sent with referral) ☐ None

Please check the exam that you are prescribing for this patient. Include all relevant records, labs and radiographs with each referral*.

☐ **Collapsing trachea** ☐ **Esophagram** ☐ **Other**

Please list any current medications*:

Case summary and working diagnosis*:

Symptoms/clinical signs*:

Veterinarian's signature*:

**Required field.*

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