FRANKLIN ANIMAL CLINIC

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Outpatient CT Referral Information Form

Date:_____

Client's Name: _____ E-mail:_____

Address: _____

Phone (primary): _____ Phone (secondary): _____

Pet's name: _____ Species: Canine / Feline / Other

Breed:_____Color:_____ DOB/Age:_____

Sex: Male / Female / Neutered Male / Spayed Female

Medical History, sensitivity to drugs/anesthesia, previous history that may cause complications:

_____

_____

Referral Information:

___Myelogram ___Abdominal ___Head/Jaw/Sinus

___Orthopedic ___Met/Tumor Check

Requesting CT Consult by Franklin Animal Clinic Veterinarian: ____Yes ____No

Reason for referral:

_____

_____

CBC and Chemistry run within 30 days of CT Imaging: ____Yes ____No

Please attach lab results, previous imaging, and pertinent records with referral information form

Referring Veterinarian:_____Clinic:_____

Address:_____

E-Mail:_____ Phone:_____ Fax:_____