**OUTPATIENT DIAGNOSTICS REFERRAL FORM**

Primary DVM Name: _____

Hospital: _____

DVM Phone: _____

Email to confirm receipt: _____

Client Name: _____

Pet Name: _____ Client Phone: _____

Species: Canine / Feline (Circle One) Breed: _____

Age: _____ Male: Neutered? Y / N Female: Spayed? Y / N

Medications (Drug Name, Dose & Frequency): _____

_____

Clinical history, physical exam findings, lab work, previous disease, etc.: _____

_____

_____

_____

_____

_____

< Please attach medical history >

I attest this patient has been examined within the last year. □

Imaging Request:

□ Preventative/Wellness Ultrasound
□ Ultrasound Guided FNA
□ Ultrasound Guided Cystocentesis
□ Pregnancy Ultrasound
□ Hematuria US
□ Prostate/Testicular US
□ Abdominal US for effusions
□ Abdominal US
□ Soft Tissue US
□ Retained Testicles (Cyrptorchid) US
□ Digital Radiograph(s)
    □ with Telemedicine Consultation
□ Dental Radiograph(s)
    □ with Telemedicine Consultation

San Francis Veterinary Hospital
16901 Shady Hills Road, Spring Hill, FL 34610
Phone: (352) 848-0940
www.SanFrancisVet.com
help@sanfrancisvet.com
Fax: 727-674-0730