ULTRASOUND REFERRAL FORM

Fax Records to: 316-744-2951 ~ Email Records to: hospital@heartlandpetcenter.com

Referring Veterinarian: _____ Referring Clinic: _____

Referring Clinic Phone: _____Referring Clinic Fax: _____

Referring Clinic Email: _____

Client Name: _____ Client Phone: (home) _____ (cell) _____

Client Address: _____ Patient Name: _____

Species: _____ Breed: _____ Color: _____ Age: _____ Sex: _____ Weight: _____ Spayed/Neutered: _____

Reason for referral: _____

_____

Clinical/Physical Exam Findings (include dates): _____

_____

Diagnostic Findings (Please send lab and radiology studies if possible): _____

_____

Tentative Diagnosis: _____

Date of Last Rabies Vaccine: ___/___/___ Current Treatment & Medications (including preventatives): _____

_____

_____

COMMENTS (any client or patient considerations, allergies, or behavior concerns): _____

_____

_____

_____

REQUEST FOR ULTRASOUND:

- ☐ Full abdominal
- ☐ Bladder
- ☐ Prostate
- ☐ Kidney: left / right
- ☐ Liver
- ☐ Adrenal Gland: left / right
- ☐ Spleen
- ☐ Gall Bladder
- ☐ Duodenum
- ☐ Pancreas
- ☐ Stomach
- ☐ Small Bowel
- ☐ Medial Iliac Vessels/Lymph Nodes

Will sedation be needed? (Additional charges apply): _____

Preferred Method of Contact for Report: _____