



Referral Request

Welcome to the Ultrasound Service! Please complete the form below and email to admin@bverh.com.

| | |
|---|--|
| Date: | |
| rDVM Information | |
| Referring Veterinarian: | Referring Veterinary Hospital: |
| Referring Veterinarian Email: | Referring Veterinarian Phone: |
| Client Information | |
| Client Name (First & Last): | Client Email: |
| Primary Client Phone: | Secondary Client Phone: |
| Client Address: | |
| Patient Information | |
| Patient Name: | Species: |
| Sex: | Breed: |
| Colour: | Date of Birth: |
| Weight (kgs): | FELV/FIV Testing Completed? X YES X No X Not Applicable |
| Does this patient require a muzzle or sedation for a full oral exam? X YES X NO | |
| Presenting Complaint: | |
| Reason for Referral: | |



Reason for Referral (Continued...)

Current Medications & Treatments:

Diagnostics (Please include if applicable):

X Labwork (blood, cytology, histopathology, etc...)

X Dental Radiographs

X Other Imaging (Rads/US/CT/MRI)

X Imaging Reports

Special Requests/Comments:

Thank you for your request! We will contact you for more complete records once the client has scheduled a consultation.