Date: _____

Available online at www.westernvet.ca

western veterinary
SPECIALIST & EMERGENCY CENTRE
A BrightHeart Hospital

1802- 10th Ave S.W. Calgary, AB T3C 0J8
Phone: (403) 770-1340 Toll Free: 1-866-770-1340
Fax: (403) 770-1344; **referral@westernvet.ca**

Appointment

Date: _____

Time: _____

Ultrasound Imaging Referral Form

Diagnostic Imaging

Tom Wilkinson
DVM

Important:

Please have clients fast their pets **(both food and water)**, if medically possible, for 12 hours prior to examination as we may need to sedate them.

Please include original copies of any lab work when sending referral form.

Owner Information

Client Name: _____

Primary Phone: ( ) _____ Additional: ( ) _____

Patient Information

Patient Name: _____ Breed: _____

Sex: F FS M MN Date of Birth: mm / dd / yyyy Weight: _____ kg

Referring Veterinarian Information

Veterinarian: _____ Hospital Name: _____

Phone: ( ) _____ Fax: ( ) _____

Email: _____

Other veterinarians involved in this case: _____

Special Communication Requests: _____

Ultrasound Examination Requested:

☐ Abdominal ☐ Small Parts (parathyroid, thyroid, salivary gland, etc) ☐ Cardiac

☐ Thoracic (mediastinum, associated plueral structures, No Cardiac Function) ☐ Other _____

If you cannot be reached and there is concern regarding the stability of the patient:

☐ Treatment by appropriate specialist if determined that situation needs to be dealt with on an emergent basis

☐ Send back to primary care facility

To aid in the diagnostic yield, please provide your clinical findings and impressions of the case, any recent laboratory tests, imaging findings and reasons for ultrasound examination.

History and Physical Finding:

_____

_____

_____

_____

_____

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_____