Animal Medical Center of Seattle

CT Referral Request Form

Referring Veterinarian:	Phone:
Referring Hospital:	Preferred Method of Contact:
Clinic Email:	Clinic Fax:

I am referring this patient to AMCS for (Please check the correct box below):

☐ CT only (imaging report will be sent directly to the referring DVM, AMCS will not consult or share results with the owner)

I prefer to receive my final imaging report via (the report will be sent within 24-48 hours):

☐ Email ☐ Fax (we will use the email/fax information listed above)

Client Information	**Pet Information**
Name:	**Name:**
Address:	**Age:**
State: **Zip:**	**Breed/Color:**
Home phone:	**Sex**
Cell phone:	**Weight:**
Email:	**Species*:**

***Please note we only see cats and dogs.**

Please attach the following supplemental information (This will assist us in preparation of a complete history for CT request forms):

☐ Pertinent medical records ☐ Lab work ☐ Radiographs (email or send with client)

Please be sure to remind your client:

☐ No food after 10pm, water is ok ☐ Bring radiographs ☐ Bring Medications

Please continue on reverse side >

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Anatomic Region of Interest:
Presenting Complaint/History:
Physical Exam Findings:
Pertinent Laboratory or Imaging Findings:
Preliminary/Tentative Diagnosis:
Specific Clinical Questions/Concerns:
Additional Comments:

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