PARTNERS
IMAGING

CT SCAN INFORMATION

- EXAM:_____
- ALLERGIES:_____
- CREAT: _____
- Date of Service: _____
- WEIGHT: _____ lbs / oz
- AGE: _____
- CONTRAST DOSE: _____

Referring Veterinarian Information

Name: _____

Facility: _____

Phone: _____

Fax: _____

Email: _____

Patient Name / Owner's Name: _____

Species: Dog / Cat / Other: _____ **Breed:** _____ **Gender:**____

Medical History: (See Below and/or See attached)

Y / N	Previous Surgery	Y / N	Foreign Metal Objects
Y / N	Surgical Clips	Y / N	Micro-Chipped
Y / N	Cancer or Tumors	Y / N	Abnormal Condition(s)

If answer to yes on the above, please provide details below. Please include any other notes below for the Interpretation

Specific Area of Interest:

_____

Diagnosis / Symptoms:

_____

_____

_____

_____

_____

REFERRING VETERINARIAN SIGNATURE: _____ DATE: _____

Office 214.521.7900 / Fax 469-844-4627