VETERINARY SPECIALTY CENTER OF DELAWARE **COMPUTED TOMOGRAPHY (CT) REFERRAL FORM** **To Be Filled Out By Referring Veterinarian** Mail to: VSCD, 290 Churchmans Rd, New Castle, DE 19720 Or Fax to: (302) 322-6883	

REFERRING VETERINARIAN INFORMATION

Referring Veterinarian:	Telephone:
Veterinary Hospital:	Fax:
	Email:
Preferred contact method: ____Fax ____Telephone ____Email	

CLIENT INFORMATION	PET INFORMATION
Client name:	Pet name:
Address:	Species: Canine ____ Feline ____ Other __________
	Breed: ____
Telephone:	Age: ________ Male ____ Female ____
Mobile:	Neutered? Yes ____ No ____

TYPE OF CT SCAN ORDERED

HEAD/NECK:	SPINE:	LIMB/JOINTS:	SOFT TISSUE:
___ Entire skull	___ C1-T2	___ Brachial plexus (L/R?)	___ Chest wall
___ Nasal cavity	___ T3-L3	___ Stifle (L/R?)	___ Lungs (met check)
___ Brain	___ L4-Sacrum	___ Elbow (L/R?)	___ Chest soft tissue
___ Osseous bullae	___ T10-Sacrum	___ Hip (L/R?)	___ Abdomen
___ Orbits	___ T3-Sacrum	___ Pelvis	___ Other
___ Sinuses	___ C1-Sacrum	___ Shoulder (L/R?)	
___ TMJ	___ Other	___ Other	
___ Soft Tissue			
___ Other			

OTHER SCAN REQUEST: ____

REASON FOR SCAN—PLEASE INCLUDE CLINICAL SIGNS AND RELEVANT HISTORY:

____

____

____

Referring veterinarian's signature____ Date ____________

VETERINARY SPECIALTY CENTER OF DELAWARE
PATIENT MEDICAL FORM FOR COMPUTED TOMOGRAPHY
To Be Filled Out By Referring Veterinarian
Mail to: VSCD, 290 Churchmans Rd, New Castle, DE 19720
Or Fax to: (302) 322-6883

CLIENT INFORMATION	REFERRING VETERINARIAN INFORMATION
Client name:	Your Name:
Address:	Hospital:
Telephone:	Telephone:

PATIENT INFORMATION

Pet name: Species: Canine ____ Feline ____ Other _____ Breed: ______________ Age: ___
Male ____ Female ____ Neutered? Yes ____ No ____ Weight: __________ lb/kg

PATIENT HISTORY:

KNOWN MEDICAL CONDITIONS:

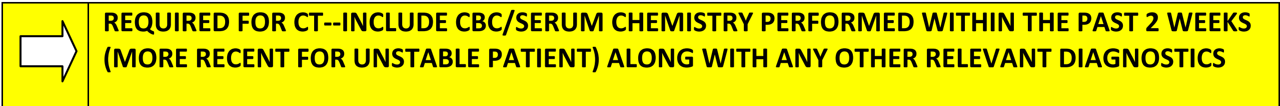
CURRENT MEDICATIONS AND DOSAGES:

PREVIOUS ANESTHETIC COMPLICATIONS:

ALLERGIES/DRUG REACTIONS:

SYSTEMS (CIRCLE, AND PLEASE EXPLAIN ANY ABNORMALITIES BELOW):

CARDIAC NORMAL ABNORMAL* **RESPIRATORY:** NORMAL ABNORMAL*
NEUROLOGIC: NORMAL ABNORMAL* **URINARY/RENAL** NORMAL ABNORMAL*
*Describe any abnormalities:



REQUIRED FOR CT--INCLUDE CBC/SERUM CHEMISTRY PERFORMED WITHIN THE PAST 2 WEEKS (MORE RECENT FOR UNSTABLE PATIENT) ALONG WITH ANY OTHER RELEVANT DIAGNOSTICS

DOES THE PATIENT HAVE OR HAS THE PATIENT HAD ANY OF THE FOLLOWING (if YES please provide details):

YES/NO/Unknown Cardiac pacemaker:
YES/NO/Unknown Orthopedic implants (plates, screws, pins, artificial joints, etc.):
YES/NO/Unknown Implanted shunts/stents/intravascular coils:
YES/NO/Unknown Gunshot wounds, embedded BBs/pellets:
YES/NO/Unknown Microchip present:
YES/NO/Unknown Foreign body ingestion:

PLEASE LIST ALL PREVIOUS SURGERIES:

The above information is correct to the best of my knowledge:

Veterinarian's Signature: ____ Date: ___________________

VSCD use only:
Reviewed and confirmed with owner (staff initials): ________ Owner initials: ________ Date: ____________