Animal Imaging
visibly better

FAX THIS ORDER TO: 972.869.9916

WE HIGHLY RECOMMEND THAT YOU SUBMIT ALL RELEVANT MEDICAL RECORDS AND LAB WORK SO WE CAN BE PREPARED FOR EACH CASE.

CT REFERRAL FORM – EQUINE

Patient Name*: Age*: Breed*:

Color*: Gender*: ☐ Mare ☐ Gelding ☐ Stallion Date of Request*:

Owner's Name*: Phone*:

Owner's Address*: City*: State*: Zip*:

Referring Veterinarian*: Preferred Contact Phone*:

Clinic Name*:

Address*:

Email*: Fax*:

Please check exam you are prescribing for this patient*:

☐ CT of Skull / Sinuses
☐ CT - Foal

Contrast (if indicated)
☐ Yes ☐ No

Specific area of interest*:

Working diagnosis and case summary*:

Symptoms/Clinical signs*:

Additional exam you are prescribing*:

Veterinarian's Signature*:

**Required field.*

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