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.

NUCLEAR MEDICINE REFERRAL FORM – EQUINE

Patient Name*: Age*: Gender*:

Breed*: Date of Request*:

Owner's Name*: Phone*:

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

Other Authorized Party/Relationship: Phone:

Referring Veterinarian*: Phone*:

Clinic Name*:

Address*:

Email*: Fax*:

Please check exam you are prescribing for this patient. Please only request one area*.

- ☐ Full Bone Scan — Tissue Phase Needed? ☐ Y ☐ N
- ☐ Front Half Bone Scan (includes cervical spine) — Tissue Phase Needed? ☐ Y ☐ N
- ☐ Back Half Bone Scan (includes cervical spine) — Tissue Phase Needed? ☐ Y ☐ N
- ☐ Region of Interest (8 images or less)

Specific area of interest*:

Reason for exam*:

Recent blocking history or joint injection history*:

Symptoms*:

Previous surgery*? ☐ Yes ☐ No

Other comments:

Additional exam you are prescribing*:

Veterinarian's signature*:

*Required field.