VCSG
Veterinary Care & Specialty Group

Outpatient Ultrasound Referral Form

Patient Name:_____

Species:_____ Breed:_____

Age:_____ Male / Female Altered : Y / N Weight: _____ Color:_____

Owner Name: _____ Phone: _____

Address:_____ Email:_____

Please send copies of medical records, radiographs, and lab results via email or fax.

Reason for Referral:_____

_____

Pertinent History:_____

_____

_____

Current Medication/Treatment:_____

_____

Referring Veterinarian:_____ Phone:_____

Address:_____

Email:_____ Date:_____

We will contact your client within 3 days to schedule. No consults or other diagnostics are included with these exams. Results will be sent to the referring vet within 24 hours of the exam.

Thank you for your referral!

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