Sechelt Animal Hospital

Diagnostic Imaging Referral Form

Dr. Lorne Carroll
Dr. Heather James
Dr. Rachael Spence

Referring Hospital:	Date:
Referring Veterinarian:	Referring DVM Phone:
Our Veterinarian will make every effort to contact the referring DVM by phone following the requested procedure to discuss the results and recommendations. In the event that the referring DVM is unavailable or cannot be contacted, our Veterinarian will review findings with the owner/agent and discuss procedures or sen out for referral if indicated. A written report will follow via fax or e-mail.	

CLIENT

Client Last Name	First Name	
Street Address	City	Postal Code
Home Phone	Cellular	E-mail

PATIENT

Name	Breed	Species	Sex M MN F FS	Age (mm/dd/yyyy)

RELEVANT HISTORY

Current Medical Concerns	**Primary Ddx or Diagnostic Questions**
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Relevant History, Comments, Special Concerns

Previous Procedures Performed **Please have client bring results or e-mail to **sah@dccnet.com***
(radiographs, ultrasound, diagnostic tests, consults)

If radiographs have not been obtained or are not available, we may obtain them if necessary.

Current Treatment/Current Medications or previously given

Follow Up

☐ Consult referring DVM regarding additional diagnostics and continuing care

☐ Treat as needed at Sechelt Animal Hospital

REQUESTED PROCEDURES **Patient Name:_____**

☐ **Abdominal Ultrasound** ☐ **Ocular Region/Eye**

☐ **Echocardiography** ☐ **Pregnancy Assessment**

☐ **Thoracic Cavity and Mediastinum-** this does not include an echocardiogram, this should be used to evaluate mediastinum, thoracic wall or pulmonary masses.

☐ **Other Area Examination (such as Neck/Thyroid, superficial masses, or musculoskeletal)**

Area Requested: _____

***Please Note:**

- We do not perform partial abdominal ultrasounds.
- Please also note that the animal will be admitted to Sechelt Animal Hospital if any complications arise from the procedures.
- Sedation may be required for ultrasound and/or procedures and will be performed as necessary with permission from the client. If pre-anaesthetic blood work has not been performed, or is not available at the time of the appointment, we will perform it prior to sedation.

This section completed by SAH

APPOINTMENT CONFIRMATION

Appt Date:	Appt Time:	Booked by:
Clinic Name:	Referring DVM e-mail address:	Referring DVM fax #:

Appointment declined by client ☐

Confirmation faxed ☐	Confirmation e-mailed ☐	Completed by
Date	Time	

The doctor will make every attempt to contact referring DVM by telephone following the requested procedure. In the event that the referring DVM is unavailable or cannot be contacted, the doctor will review findings with the owner/agent and discuss available procedures as indicated. A written report will follow via fax or e-mail.

Please ensure BOTH pages are completed and returned to our office by fax or e-mail. Once you have sent your referral, we will contact your client to book an appointment. Confirmation will follow.

Phone 604-885-2309 Fax 604-514-1712 E-mail sah@dccnet.com

Once you have sent your referral, please contact our office to confirm receipt