



**Arizona Veterinary Imaging, PLLC
dba Desert Veterinary Medical
Specialists**

86 West Juniper Avenue
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Gilbert, Arizona 85233
Phone: (480) 635-1110 x6
Fax: (480) 892-0540

Radiology Services Referral Form

Referring Veterinarian's Name: _____ **Date** _____

Hospital Name: _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: (____) _____ **FAX:** (____) _____

E-mail: _____

Client Name: _____

Home Phone: (____) _____ **Cell/Other:** (____) _____

Patient's Name: _____ **Species:** _____

Breed: _____ **Date of Birth:** _____

Sex: _____ **Altered?** Y N

**Medical History/
Physical Exam Findings:** _____

Radiographs	Ultrasound	CT/MRI Interp.
<input type="checkbox"/> Study by AVI <input type="checkbox"/> Interpretation Number of views ____ Thorax <input type="checkbox"/> 2 view <input type="checkbox"/> 3 view <input type="checkbox"/> Neck <input type="checkbox"/> Esophagram <input type="checkbox"/> Other _____ Abdomen <input type="checkbox"/> Survey Number of views: _____ <input type="checkbox"/> Upper GI Study <input type="checkbox"/> Cystogram <input type="checkbox"/> IV Pyelogram <input type="checkbox"/> Other _____ Spine <input type="checkbox"/> Cervical Spine <input type="checkbox"/> C/T Spine <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> T/L Spine <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Lumbosacral Spine <input type="checkbox"/> Full Spine	Orthopedic <input type="checkbox"/> Left <input type="checkbox"/> Right Forelimb <input type="checkbox"/> Scapula <input type="checkbox"/> Shoulder <input type="checkbox"/> Humerus <input type="checkbox"/> Elbow <input type="checkbox"/> Antebrachium <input type="checkbox"/> Carpus <input type="checkbox"/> Forepaw Hindlimb <input type="checkbox"/> Pelvis <input type="checkbox"/> Femur <input type="checkbox"/> Stifle <input type="checkbox"/> Tibia <input type="checkbox"/> Tarsus <input type="checkbox"/> Hindpaw	<input type="checkbox"/> Outpatient <input type="checkbox"/> Interpretation <input type="checkbox"/> Abdomen <input type="checkbox"/> Portosystemic Shunt <input type="checkbox"/> Non-cardiac Thorax <input type="checkbox"/> Thyroid/Neck <input type="checkbox"/> Musculoskeletal Body part: _____ <input type="checkbox"/> US guided FNA <input type="checkbox"/> US guided Biopsies <input type="checkbox"/> US-guided Palliative Centesis
	Nuclear Medicine <input type="checkbox"/> GFR Scan <input type="checkbox"/> Regional Bone Scan Body Part: _____ <input type="checkbox"/> Whole Body Bone Scan <input type="checkbox"/> Thyroid Scan <input type="checkbox"/> Portosystemic Shunt	<input type="checkbox"/> Nasal/Head <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Thorax <input type="checkbox"/> Abdomen <input type="checkbox"/> Musculoskeletal Body part: _____ Please send my report via <input type="checkbox"/> Fax <input type="checkbox"/> E-mail
<p>For patients referred directly to Arizona Veterinary Imaging, PLLC for radiographs studies or procedures, please read and initial the following: I have performed a complete physical exam and found this patient stable and healthy enough for sedation or anesthesia necessary to complete the requested studies. Animals at increased risk due to illness will be evaluated by a specialist at Arizona Veterinary Internal Medicine, PLLC or the Emergency Animal Clinic, PLLC.</p> <p>_____ (Referring Doctors Initials)</p>		

Please attach additional pages including medical records and original lab reports directly relating to this medical condition. Please send pertinent radiographs or other diagnostic images. Charges will be assessed on a standard per study basis. Please call our doctor if there is any immediate information you need to relay about this case. Thank you for the opportunity to participate in the treatment of this patient.