

**CT scan Referral Form**

* Medical records and updated blood testing (CBC/chem in the last 4 weeks) are required prior to CT scan to aid anesthesia or sedation.
* If thoracic CT scan is requested, please provide copies of thoracic radiographs (performed in the last 4 weeks) for review. If pleural space disease is present, thoracocentesis may be required prior to performing the scan.
* Critical patients will require stabilization prior to CT scan and some patients may be deemed too unstable to have this procedure performed. Please discuss any questions regarding the stability of your patient directly with our staff. We cannot guarantee CT scan will be available during patient hospitalization as this depends on specific staff being present for operation.

Referring Veterinary Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Veterinarian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Hospital Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (or) Fax number for results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospital Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name: \_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_ Age of patient: \_\_\_\_\_\_\_\_

Species: \_\_\_\_\_\_\_\_\_\_\_ Breed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_

**Imaging requested:**

Note: Additional charges assessed for each additional location imaged.

* Skull/Head (Nasal cavity and sinuses, bulla)
* Thorax
* Abdomen
* Spine (Please circle each level requested, additional fees per level)
  1. Cervical b) Thoracic c) Lumbar
* Pelvis
* Shoulders: a) Left b) Right c) Both
* Stifles or elbows: a) Left b) Right c) Both
* Carpi or tarsi including distal structures: a) Left b) Right c) Both

**Please fax or email this form along with other required patient information to 301-733-7735 or** [**CTscan@MVAEvet.com**](mailto:CTscan@MVAEvet.com)**.**