LUBBOCK SMALL ANIMAL EMERGENCY CLINIC

CT referral sheet:

Date of Referral: _____

Referral Clinic: _____

Address: _____

Clinic Phone: _____
Name of Doctor: _____

e-mail for radiologist report:

_____

Doctor Phone Number: _____

Client Name: _____

Client Phone#: _____

Patient Name: _____

Patient DOB: _____

Sex (Spayed or Neutered) _____

Breed: _____

Scan Requested:

□ **skull/dental/sinuses** □ **thoracic** □ **abdomen**

□ **Spine (cervical, thoracic, lumbar) -please circle desired location (or full spine check here □)**

□ **other: _____**

□ **with contrast** □ **no contrast**

Patient History:

Diagnosis:

Notes to the Radiologist:

Please send via 1. e-mail to: info@lubbockemergencyvets.com 2. Text: 806-752-0999