



Out-Patient Ultrasound Clinic Referral Form

Clinic/Hospital Name: _____

Referring Veterinarian: _____

Vet's Preferred Contact Number: _____

Pet Owner's First & Last Name: _____

Pet Owner's Phone: _____

Pet Owner's Email: _____

Patient Name: _____ Use Caution? **Y** or **N**

Species: _____ Breed: _____

Age: _____ Sex: _____ Weight: _____

Region to be scanned (abdomen, non-echocardiogram thorax, focal, echocardiogram):

Please provide a brief reason for referral (i.e: mass in abdomen, heart murmur, elevated liver values, etc): _____

- Check box to pre-approve aspirates. Bloodwork showing adequate PLT must be sent to pre-approve.
 Check box to waive the follow up phone call for normal or NSF ultrasound findings. A report will still be sent.

Send your referral and a copy of the patient's recent/relevant medical records (including lab results and imaging if available) to **outpatientultrasound@vitalrads.com**.

The VitalRads Outpatient Ultrasound Team will reach out directly to the client to schedule their pet's appointment. The client will pay VitalRads directly and your hospital will not be billed.

Please remember that we are not a full-service clinic and are not able to support critical or very ill patients. We do not have the equipment or staff to provide medical intervention if a patient were to decompensate or crash and therefore, all referred patients must be able to undergo the requested imaging without medical support. By checking the box below, you are acknowledging that the referred patient is stable and unlikely to decompensate during imaging at our facility.

I/we believe that this patient is stable at the time of referral and unlikely to decline or decompensate during imaging at the VitalRads Outpatient Ultrasound Service facility.

Thank you for choosing VitalRads, we look forward to assisting you with your ultrasound needs!