Heartland Animal Hospital

319.373.8387 – 991 62nd Street Marion, IA 52302 – hahmarionia@gmail.com

Referral Information – Referring DVM Name: _____

Practice Name: _____ Phone: _____ Email: _____

Client Information – Name: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

Patient Information– Name:_____Gender:_____

Species: _____ Breed: _____ Weight**:** _____ DOB: _____

Differential Diagnosis:_____

Case History: _____

_____

_____

****Please attach Bloodwork Results(CBC & Chem 10-minimum) done in the past 14 days or it will be done for an additional charge at the time of the CT.** ** Please attach any other applicable tests.**

Treatment: _____

_____

Requested CT Images

Skull	Hip (right or left)
Sinuses	Stifle (right or left)
Spine (specify segment-cervical/thoracic/lumbar)	Shoulder (right or left)
Abdomen	Elbow (right or left)
Thorax	Carpus (right or left)

*Definition of site- 1 region of interest (i.e. Elbow, hip, sinuses etc.) *Selecting multiple sites will increase cost.

Referral Agreement

It is the policy of Heartland Animal Hospital to service your pet ONLY for the specific procedure for which you have been referred. We cannot provide any veterinary care other than what is requested by your pet's primary veterinarian. Consistent with our veterinary ethics it is important that you continue with veterinary care with your pet's primary veterinarian.

I understand my pet is being referred to Heartland Animal Hospital for CT Imaging ONLY. I have read and agree to the above referral agreement with Heartland Animal Hospital.

_____ _____

Client signature **Date**