LIVE OAK
ANIMAL HOSPITAL

CT Referral Sheet:

Date of Referral: _____

Referral Clinic: _____

Clinic Phone: _____

Name of Referring Veterinarian:

_____

Client Name: _____

Client Phone: _____

Patient Name: _____

Patient DOB: _____

Sex (Spayed or Neutered): _____

Scan Requested:

☐ **Skull/Dental/Sinuses** ☐ **Thoracic** ☐ **Extremities**

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

☐ **With contrast** ☐ **Without contrast**

☐ **Other:** _____

Patient History:

Diagnosis:

Notes to the Radiologist: