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Diagnostic Imaging Procedure Request Form

Patients should be fasted for more than 8 hours before procedures requiring anesthesia. This completed form as well as a copy of recent laboratory evaluations should accompany the patient for the procedure.

VHA exam requested No exam

RDVM Information	
Name: _____	Patient Name: _____
Practice: _____	Client Name: _____
Address: _____	Species: _____
Phone/Fax: _____ / _____	Sex: <input type="checkbox"/> male <input type="checkbox"/> female Neutered: <input type="checkbox"/> yes <input type="checkbox"/> no
Email: _____	Breed: _____
<i>formatted to facilitate the use of pre-printed labels</i>	Age: _____ Weight: _____
	<i>formatted to facilitate the use of pre-printed labels</i>

Computed Tomography			
<input type="checkbox"/> survey	<input type="checkbox"/> Abdomen	<input type="checkbox"/> brain	<input type="checkbox"/> Cranium
<input type="checkbox"/> liver	<input type="checkbox"/> adrenal/renal	<input type="checkbox"/> orbit	<input type="checkbox"/> R <input type="checkbox"/> L
	<input type="checkbox"/> bladder-prost-ureth		<input type="checkbox"/> nasal
			<input type="checkbox"/> bulla
<input type="checkbox"/> lungs	<input type="checkbox"/> Thorax	Musculoskeletal	
<input type="checkbox"/> body wall	<input type="checkbox"/> mediastinum	Describe: _____	
	<input type="checkbox"/> brachial plexus	Spine - select region(s)	
		<input type="checkbox"/> Cervical (C1-T2)	
		<input type="checkbox"/> Thoracic (T3 -L3)	
		<input type="checkbox"/> Lumbosacral (L4 - S2)	
		Cervical - soft tissue	
		<input type="checkbox"/> pharynx/larynx <input type="checkbox"/> thyroid	

Magnetic Resonance Imaging			
<input type="checkbox"/> liver	<input type="checkbox"/> Abdomen	<input type="checkbox"/> brain	<input type="checkbox"/> Cranium
<input type="checkbox"/> survey	<input type="checkbox"/> adrenal/renal	<input type="checkbox"/> orbit	<input type="checkbox"/> R <input type="checkbox"/> L
	<input type="checkbox"/> bladder-prost-ureth		<input type="checkbox"/> nasal
			<input type="checkbox"/> bulla
<input type="checkbox"/> lungs	<input type="checkbox"/> Thorax	Musculoskeletal	
<input type="checkbox"/> body wall	<input type="checkbox"/> brachial plexus	Describe: _____	
	<input type="checkbox"/> mediastinum	Spine - select region(s)	
		<input type="checkbox"/> Cervical (C1-T2)	
		<input type="checkbox"/> Thoracic (T3 -L3)	
		<input type="checkbox"/> Lumbosacral (L4 - S2)	
		Cervical - soft tissue	
		<input type="checkbox"/> pharynx/larynx <input type="checkbox"/> thyroid	

Ultrasound / Other			
<input type="checkbox"/> Abdomen	<input type="checkbox"/> Thorax	<input type="checkbox"/> Other _____	<input type="checkbox"/> Echocardiogram

1. Due to the need for injectable and/or gas anesthesia for advanced imaging and the use of contrast agents, a current (within 1 month) CBC/biochemistry and urinalysis is required. Risks of using contrast agents may lead to acute renal failure or anaphylactic shock.
2. All medical records and current bloodwork/urinalysis are required prior to scheduling imaging. Please send all information to referrals@vhavets.com
3. As the referring veterinarian, I understand that without an examination and consultation with a Veterinary Healthcare Associates doctor or specialist, I take full responsibility for the general health of this patient and that this patient is safe to undergo anesthesia. I also understand that I am responsible for the decisions regarding what imaging modality to use and what anatomy to image. VHA will not be discussing the imaging results with the client or making recommendations and will forward the results to me as soon as they are available.
4. To improve efficiency, Veterinary Healthcare Associates will communicate only with the doctor/clinic requesting the imaging and not the client.

History / Clinical Signs / Laboratory / Previous Diagnostic Tests / Special Requests