Ultrasound Referral

Sackville Animal Hospital

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Lower Sackville, NS B4C 2S1
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sackvilleanimalhospital.ca

PLEASE SUBMIT A CASE SUMMARY WITH THIS REFERRAL FORM

☐ URGENT ☐ NON URGENT

HOSPITAL INFORMATION

Referring Hospital: _____

Phone: _____ Fax: _____

Email: _____

Referring Veterinarian: _____

PATIENT INFORMATION

Patient Name: _____ Species: _____

Breed: _____ DOB: _____

Sex: _____ Color: _____

Referral Service:

☐ Abdominal Ultrasound
☐ Abdominal Ultrasound with Biopsy/FNA
☐ U/S Assisted Liver Core Biopsy
☐ Other: _____

CLIENT INFORMATION

Client Name: _____ Spouse/Add'l Persons: _____

Address: _____

Phone: _____ Email: _____

- *Please fax or e-mail referral form **along with a brief case summary** and recent medical notes, including any diagnostics pertinent to the history. Please review your referral package for specific information, including indications, preparatory information, etc, to pass along to the client in preparation for their visit. We will contact them to arrange their appointment time directly, unless otherwise arranged through you.
- Please inform clients that their pet will have their abdomen shaved and possibly given a sedative prior to ultrasound.
- All patients require a 12 hour fast, and preferably a full bladder.

Referring Veterinarian Signature: _____
(Electronic if completed on-line or signed if scanned/faxed)