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Radioactive Iodine Therapy Hyperthyroid Cat – Referral Form

REFERRING VETERINARY INFORMATION

Dr. _____ Hospital Name: _____
 Date: _____ Phone Number: _____ Fax Number: _____
 Email: _____

CLIENT INFORMATION

Name: _____
 Address: _____ City: _____ Prov: _____ Postal Code: _____
 Contact Number: _____ Email: _____

PATIENT INFORMATION

Name: _____ Species: _____ Breed: _____ D.O.B: _____
 Sex: M F Neutered/Spayed: Yes No Colour: _____ Weight: _____
 Vaccine Status: _____ Underlying Condition: _____

HISTORY

Please include the following information with your referral request:

1. Date of diagnosis
2. Most recent CBC/Chem/Urinalysis (*if available*)
3. Reference lab Total T4 levels (*if available*)

Date	TT4	Medication

4. Weight history for 12-24 months preceding referral (*if available*)

Date	Weight