Radioiodine Therapy Referral Checklist

Date: _____

Patient Name: _____

Owner Name: _____

Referring Veterinarian & Clinic: _____

Contact Information: _____

Please complete this form and submit it via our website, email (**referrals@riverviewah.ca**), or fax (**506-387-7656**). Attach any relevant medical records or additional notes.

1. Required Diagnostics (within 1–3 months of treatment):

- CBC
- Chemistry panel
- Quantitative T4 (in house T4 is acceptable – we need to see a # value as opposed to “normal” or “abnormal”)
- Complete urinalysis

Additional recommendations:

- **Cardiac concerns (arrhythmia or murmur):** ECG, ultrasound, or radiographs
- **Abnormal bloodwork or palpable masses:** Abdominal imaging
- **Optional:** Full body survey radiographs

2. Thyroid Levels

- Pre-treatment T4: nmol/L (Date: _____)
- Highest recorded T4: nmol/L (Date: _____)

3. Clinical Assessment

Please indicate severity:

- **Weight loss:** Mild / Moderate / Severe
- **Polyuria:** Yes / No
- **Polydipsia:** Yes / No
- **Heart rate:** bpm
- **Heart murmur (grade):** _____
- **Panting/Tachypnea:** Yes / No
- **Hyperexcitability:** Yes / No

If HR > 240 bpm, please start atenolol before referral.

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4. Appetite

☐ Voracious ☐ Good ☐ Fair ☐ Picky

If on a prescription diet, please advise the owner to bring a **10 day supply**.

5. Thyroid Nodule Size

- **Right:** _____ cm
- **Left:** _____ cm

6. Medications During Hospitalization

List all medications required during the stay, including **name, dose, and frequency**.
If atenolol is prescribed, please provide a **2-week supply** and instruct the owner to bring it.

7. Concurrent Conditions

List any medical issues that may affect hospitalization:

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8. Temperament

☐ Friendly ☐ Shy ☐ Fearful ☐ Fractious

9. Stress-Related Anorexia

☐ Yes ☐ No ☐ Unsure

10. Additional Notes

Please include any other relevant information:

Thank you for your referral and for helping us provide the best care possible.

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