



Radioiodine Therapy Referral Form

Owner's Name: _____ Patient's Name: _____

Breed: _____ Age: _____ Sex: F M Spayed/Neutered

Owner's Email: _____ Owner's Phone Number: _____

Referring Hospital: _____

Referring Veterinarian: _____ Contact Number: _____

Patient History – Include any adverse drug reactions, previous illness, or surgery.

Current treatments and response to therapy (please attach all pertinent lab results).

Any additional comments:
