Outpatient Imaging CT - Request Form

OREV SPECIALTY VET CARE

Pet Name: ☐ Canine ☐ Feline ☐ Male ☐ Female Age/DOB

Neutered/Spayed? ☐ Yes ☐ No Patient weight: Breed:

Client Name:

Client Phone: Client E-mail:

Referring Clinic:

Referring Veterinarian: Phone:

E-mail / Fax for sending results:

Pertinent History, please include any additional medical history or concern we should be aware of:

Anesthetic concerns: ☐ Yes ☐ No If Yes, Explain:

Recent Radiographs: ☐ Yes ☐ No

Recent Blood-work: ☐ Yes ☐ No BW REQUIRED! Must be completed within 4 weeks of CT scan. If not, can be subject to reschedule, thank you for your cooperation.

Study Requested:

☐ Skull	Add Contrast study	☐ Yes	☐ No
☐ Neck	Add Contrast study	☐ Yes	☐ No
☐ Thorax and Met-check	Add Contrast study	☐ Yes	☐ No
☐ Abdominal	Add Contrast study	☐ Yes	☐ No
☐ Extremity / Orthopedic	Add Contrast study	☐ Yes	☐ No
☐ Cervical Spine	Add Contrast study	☐ Yes	☐ No

Specify:

PLEASE send completed form and records to records@orev.vet.

7637 SW 33rd Ave., Portland, OR 97219 • 503.477.7122 • records@orev.vet • www.orev.vet