Outpatient Exams Located At:

4631 Citylake Blvd West
Fort Worth, TX 76132
Phone: 817-263-2900
Fax: 817-263-2901

eIMAGING OUTPATIENT REFERRAL FORM

Referring Veterinarian Information

Doctor Name: ______________________________ Dr. phone: _________________

Hospital Name: _____________________________ 2nd phone: _________________

Email: ____

Client Information

Client Name: ________________________________ Client Phone: ______________

Client Address: ______________________________ 2nd Phone: _______________

City/State/Zip: __________________________________

Patient Information

Patient Name: ____________________________________ Species: Dog Cat

Breed: ____ Sex: M F MN FS

Age/DOB: _______________________________________

Imaging to be Performed:

◯ Abdominal Ultrasound ◯ Echocardiogram

Reason for Referral

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Tentative Diagnosis/DDX:

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Diagnostics Performed Results

Blood Work Y N ____

Urinalysis Y N ____

Radiographs Y N ____

After submitting form, please fax or email all pertinent medical records, test results and images to:
(Please send radiographs with owner if not digital)

fortworthaeh@gmail.com Fax: 817-263-2901