

Pittsburgh, PA Office
 807 Camp Horne Road
 Pittsburgh, PA 15237
 PHONE 412.348.2577
 FAX 412.774.1999



Akron, OH Office
 1321 Centerview Circle
 Copley, OH 44321
 PHONE 330.576.6275
 FAX 330.319.7445

MRI / CT REFERRAL FORM

Please complete the following and fax together with all necessary paperwork to your local imaging center.

General Information

- It is very important to note that your patient will be anesthetized for the MRI/CT. Please advise your clients as to the risks of anesthesia as well as any special instructions regarding medications to be given before the MRI/CT.
- We are not equipped to handle laboratory testing or imaging other than MRI/CT. Therefore, all required testing must be completed by you and results furnished prior to our anesthetizing your patient. A list of required tests has been provided. Do not hesitate to contact us should you have any specific questions.
- We strongly recommend that a radiograph of the area to be imaged is obtained before anesthetizing your patient as metallic objects such as bullets or BBs near the area of interest can prevent us from getting a diagnostic exam.
- As we are an outpatient facility only, patients must be stabilized before we can proceed with a MRI/CT.

Referring Veterinarian Information

Clinic Name _____
 Veterinarian #1 _____ Veterinarian #2 _____
 Address _____ City _____ State _____ Zip _____
 Clinic Number _____ Fax Number _____

Client and Patient Information

Client's Name _____ Home # _____
 Address _____ Cell # / Work # _____
 City, State, Zip _____ E-mail address _____
 Patient Name _____ Species _____ Sex _____
 Breed _____ Color _____ Weight _____ Age _____

Case History and Medical Information

Please indicate patient history including past and current medical problem(s), results of all diagnostic testing, any medication(s) prescribed, and response to medication(s), if any. Please include any sensitivity to anesthesia or any known allergies. Please feel free to attach additional patient history as necessary.

1. AREA TO BE IMAGED (please check/circle)

SPINE	BRAIN	HEAD/NECK	LIMB/JOINTS	SOFT TISSUE
<input type="checkbox"/> C1-T2	<input type="checkbox"/> Brain	<input type="checkbox"/> Nasal Cavity	<input type="checkbox"/> Brachial Plexus (L / R)	<input type="checkbox"/> Abdomen
<input type="checkbox"/> T3-L3		<input type="checkbox"/> Osseous Bullae	<input type="checkbox"/> Lumbosacral Plexus	<input type="checkbox"/> Chest Wall
<input type="checkbox"/> L4-Sacrum		<input type="checkbox"/> Orbits	<input type="checkbox"/> Stifle (L / R)	<input type="checkbox"/> Lungs
<input type="checkbox"/> T3-Sacrum		<input type="checkbox"/> Sinus	<input type="checkbox"/> Elbow (L / R)	(Mets eval)
<input type="checkbox"/> C1-Sacrum (double study)		<input type="checkbox"/> Soft Tissue Neck	<input type="checkbox"/> Hip (L / R)	
			<input type="checkbox"/> Pelvis (L / R)	
			<input type="checkbox"/> Shoulder (L / R)	

2. SPECIFIC SEQUENCES REQUESTED (please check):

Standard MRI Standard CT Other (specify) _____

Signature of Veterinarian Requesting Test _____ **KS**