PetFocus Veterinary Hospital
BEDFORD SOUTH

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Ultrasound Referral Form

Referring Hospital: _____ Veterinarian: _____

Phone Number: _____ Fax: _____ Email: _____

Stat: ☐

CLIENT INFORMATION

Name: _____

Address: _____

Contact Number: _____ Email: _____

PATIENT INFORMATION

Name: _____ Breed: _____ D.O.B: _____

Sex: ☐ M ☐ F Neutered/Spayed: ☐ Yes ☐ No Colour: _____ Weight: _____

Allergies: _____

Relevant History:

A 12-hour fast period is required prior to the ultrasound. Water is allowed and if possible, we would like a full bladder. The ultrasound appointment will take approximately 1 hour. Results are sent to the referring veterinarian as soon as possible. We kindly ask that you send any important information related to this case, along with the referral form, via fax or email. Please indicate below how you would prefer to receive results. We are happy to answer any questions you may have. Thank you for entrusting us with the care of your patient.

I would like test results sent to me via: ☐ **Fax** ☐ **Email**

Requested by: _____ Date: _____